

Case Number:	CM15-0086676		
Date Assigned:	05/08/2015	Date of Injury:	10/21/2008
Decision Date:	07/14/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/05/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 53-year-old female who sustained an industrial injury on 10/21/08. Injury occurred when her low back was forced into a door handle. She was diagnosed with a disc herniation and underwent lumbar laminectomy on 3/1/10. Records indicated that the injured worker had worsening back pain radiating to bilateral lower extremities. Conservative treatment had included medications, activity modification, and lumbar epidural steroid injections which had little benefit. The 2/25/15 lumbar spine MRI impression documented status post discectomy at L4/5 without evidence of recurrent or residual disc disease. There was mild facet arthropathy extending from L2/3 through L5/S1 without significant neuroforaminal narrowing. The 3/31/15 treating physician report cited worsening low back and bilateral radicular symptoms. She had undergone a recent second opinion who suggested that an L4/5 lumbar fusion would be a reasonable treatment option. She had undergone lumbar epidural steroid injection in the past which have not been of much better. Physical exam documented midline lower lumbar and paraspinal tenderness to palpation, limited range of motion, positive straight leg raise, and trace bilateral ankle dorsiflexion weakness. Imaging showed advanced collapse at the L4/5 level with foraminal narrowing and retrolisthesis. Authorization was requested for anterior lumbar interbody fusion at L4/5 with instrumentation. Additional associated surgical requests include purchase of a hot/cold therapy unit and wrap, and purchase of a lumbar brace. The 4/16/15 utilization review certified the request for anterior lumbar interbody fusion at L4/5 with instrumentation. The associated request for a hot/cold therapy unit with wrap purchase was

modified to a cold therapy unit rental for 7 days and purchase of the wrap. The request for a lumbar brace was modified to purchase of a standard lumbar brace.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Associated service: lumbar brace purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back 1/2 Lumbar & Thoracic: Lumbar supports.

Decision rationale: The California MTUS guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The Official Disability Guidelines state that post-operative (fusion) back braces are under study and cite conflicting information. Guidelines recommend a case-by-case review and indicate a standard brace would be preferred over a custom post-op brace. The use of a lumbar support in the post-operative period for pain control may be considered reasonable. However, the 4/16/15 utilization review modified this request to certification of a standard lumbar brace. The medical necessity of additional certification is not supported by the submitted records. Therefore, this request is not medically necessary.

Associated service: Hot/cold therapy unit with wrap purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

Decision rationale: The California MTUS are silent regarding hot/cold therapy devices, but recommend at home applications of hot or cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a hot/cold therapy unit in the absence of guideline support. Therefore, this request is not medically necessary.