

<b>Case Number:</b>	CM14-0216133		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	02/25/2013
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/24/2014

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 patient is a 35 year old male with an injury date of 02/25/13. The orthopedic spine surgeon's progress report dated 11/18/14 states that the patient presents with constant lower back pain rated 7/10 with intermittent numbness radiating to the right buttocks, down the right posterior thigh through the calf to the foot and toes. Lower extremity pain is rated 3/10. Examination of the lumbar spine and lower extremities reveals tenderness to palpation over the lumbar paravertebral muscles bilaterally with decreased sensation over the right L5 and S1 dermatomes. The patient's diagnoses include: 1. L4-L5 and L5-S1 disc degeneration. 2. L4-S1 disc displacement. 3. L5-S1 stenosis. 4. Right leg radiculopathy. 5. Chronic intractable pain. Medications are listed as Norco and Zanaflex. The patient is s/p discogram 11/10/14. The treater states the patient has failed conservative treatment and is recommending a TDA for L4-5 and AP fusion L5-S1. The utilization review is dated 12/02/14. Reports were provided for review from 06/19/14 to 11/18/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) pneumatic intermittent compression device: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, DVT

**Decision rationale:** The patient presents with constant lower back pain radiating down the right buttocks to the right thigh, calf foot and toes. Pain is rated 3-7/10. The current request is for 1 PNEUMATIC INTERMITTENT COMPRESSION DEVICE. The RFA is not included. The 12/02/14 utilization review states the RFA is dated 11/24/14 and is a prospective request for the period 11/25/14 to 01/09/15. The most recent report provided for review is dated 11/18/14. MTUS and ODG do not discuss pneumatic compression therapy for the lower back. ODG guidelines under Knee Chapter, DVT, does address post-operative treatments for DVT prophylaxis. The National Guidelines Clearinghouse also recommends "mechanical compression devices in the lower extremities are suggested in elective spinal surgery to decrease the incidence of thromboembolic complications." For duration of use, it recommends it from just prior to or at the beginning of surgery and continuation until the patient is fully ambulatory. In this case, the reason for this request is not discussed in the reports provided. Presumably it is for post-surgical treatment as the treating physician is recommending a TDA for L4-5 and AP fusion L5-S1. It is unknown if this surgery is authorized. In this case, the request as presented above is for an indeterminate period, the reports do not state that the request is for treatment of post-operative DVT, and there is no evidence that surgery has been authorized. The request IS NOT medically necessary.

**One (1) lumbar-sacral orthosis back brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Lumbar & Thoracic Chapter, lumbar supports post-operative bracing

**Decision rationale:** The patient presents with constant lower back pain radiating down the right buttocks to the right thigh, calf foot and toes. Pain is rated 3-7/10. The current request is for 1 LUMBAR- SACRAL ORTHOSIS BACK BRACE. The RFA is not included. The 12/02/14 utilization review states the RFA is dated 11/24/14 and is a prospective request for the period 11/25/14 to 01/09/15. ACOEM guidelines page 301 on lumbar bracing state, Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG Low Back Lumbar & Thoracic Chapter, lumbar supports topic, states, Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). For post-operative bracing, ODG states, "Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician."The

treater does not discuss this request in the reports provided. Presumably it is for post-surgical treatment as the treating physician is recommending a TDA for L4-5 and AP fusion L5-S1. It is unknown if this surgery is authorized. Lacking a clear statement of the need for this request it IS NOT medically necessary.

**30 days rental of cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Continuous-flow cryotherapy

**Decision rationale:** The patient presents with constant lower back pain radiating down the right buttocks to the right thigh, calf foot and toes. Pain is rated 3-7/10. The current request is for 30 DAYS RENTAL OF COLD THERAPY UNIT The RFA is not included. The 12/02/14 utilization review states the RFA is dated 11/24/14 and is a prospective request for the period 11/25/14 to 01/09/15. The most recent report provided for review is dated 11/18/14. ODG does not discuss cryotherapy units for the lower back. ODG, Knee & Leg Chapter, Continuous-flow cryotherapy, states it is recommended as an option after surgery for up to 7 days including home use. In this case, guidelines support some uses of the requested unit for up to 7 days following surgery. The treater does not discuss this request in the reports provided. The requested 30 days is beyond the 7 days recommended by ODG. Furthermore, guidelines do not state use is recommended for the lower back. The request IS NOT medically necessary.