

Case Number:	CM15-0110460		
Date Assigned:	06/17/2015	Date of Injury:	08/21/2013
Decision Date:	07/15/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/08/2015

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 31-year-old male who sustained an industrial injury on 8/21/13. Injury occurred when he stepped on a piece of fiber on the floor and fell on his right side. The 1/31/14 lumbar spine MRI impression documented mild multilevel degenerative changes and a mildly congenitally narrowed spinal canal with short pedicles. At L5/S1, there was a 6 mm broad-based central disc protrusion indenting the anterior thecal sac and, combined with mildly congenitally narrowed spinal canal with short pedicles, resulted in mild central canal stenosis with a canal diameter of 7-8 mm and mild left lateral recess stenosis. There was a mild diffuse disc bulge and very mild bilateral facet arthropathy resulting in mild bilateral neuroforaminal stenosis. The 2/4/15 treating physician report cited low back pain radiating to both legs with weakness and tingling. He had not responded to conservative treatment that included physical therapy, chiropractic care, acupuncture, bracing, anti-inflammatory medications, and epidural injections. Physical exam documented paravertebral muscle tenderness, guarding and spasms, 4/5 trunk strength, moderate loss of range of motion, decreased left L4, L5, and S1 sensation, and 4/5 left extensor hallucis longus weakness. The diagnosis was lumbar disc protrusion, and lumbar radiculopathy. Authorization was requested for left sided L5/S1 laminectomy/laminotomy and decompression. Associated surgical requests were also requested including a post-operative back brace and cold therapy unit. The 5/22/15 utilization review certified the request for left sided L5/S1 laminectomy/laminotomy and decompression with pre-operative medical clearance and post-op physical therapy 3x4. The request for a post-operative back brace was non-certified as there was no efficacy for use in lumbar decompression. The request for a cold therapy unit was

non-certified as there was no additional clinical utility or impact on health outcome of a cold therapy unit over the use of ice or compression wraps.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post Operative Back Brace: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Lumbar spine, general bracing.

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 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) page(s) 138-139.

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 revised ACOEM Low Back Disorder guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. The use of a lumbar support in the post-operative period for pain control is reasonable and supported by guidelines. Therefore, this request is medically necessary.

Post Operative Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Lumbar spine, Cold packs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. 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.