

Case Number:	CM15-0092694		
Date Assigned:	05/19/2015	Date of Injury:	01/10/2013
Decision Date:	09/24/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	05/13/2015

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: California, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 51-year-old male, who sustained an industrial injury on January 10, 2013. He reported a sharp pain in his low back. Treatment to date has included medication, MRI, epidural injections, physical therapy, pain management, acupuncture and toxicology screen. Currently, the injured worker complains of left sided low back pain that radiates down his left buttock and the back of his left thigh. The pain will occasionally travel into his left calf. He also reports intermittent right thigh numbness. The injured worker is currently diagnosed with lumbago. His work status is temporary partial disability, modified duty. A note dated February 24, 2015, states the injured worker experienced temporary relief from acupuncture. A progress note dated April 15, 2015 states the injured worker did not receive long-term therapeutic benefit from epidural injections and physical therapy. The injured worker reports a decrease in pain from 8 on 10 to 7 on 10 with medication, per note dated April 24, 2015. The following equipment; LSO back brace, cold therapy unit (30-day rental) and pneumatic intermittent compression device are requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

LSO Back Brace: 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): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Lumbar supports.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, LSO back brace is not medically necessary. Lumbar supports have not been shown to have lasting effect beyond the acute phase of symptom relief. Lumbar supports are not recommended or prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. Additionally, lumbar supports to not prevent low back pain. In this case, the injured worker's working diagnoses are L4 - S1 disc degeneration; L4 - L5 left; L4 - S1 mild lateral recess stenosis; L4 - S1 facet arthropathy; left leg radiculopathy versus pseudo-radiculopathy due to facet arthropathy; and chronic lumbago. According to an April 15, 2015 progress notes, the treating provider requested a left L4 - L5 and L5 - S1 laminotomy and foraminotomy and right-sided L4 - L5 laminotomy and foraminotomy with intraoperative spinal cord monitoring. The LSO back brace and cold therapy unit 30-day rental are indicated based on whether the surgery is clinically indicated, medically necessary and approved. The documentation in the medical record does not contain a subsequent progress note (to the April 15, 2015 progress note). There is no documentation indicating whether the surgery was approved. Lumbar supports are not recommended or prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. This review presumes that the surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. This request is not medically necessary.

Cold Therapy Unit (30 Day Rental): 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Continuous flow cryotherapy.

Decision rationale: Pursuant to the Official Disability Guidelines, cold therapy unit 30-day rental is not medically necessary. Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use maybe for up to 7 days, including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling and narcotic use; however, the effect on more frequently treated acute injuries has not been fully evaluated. In this case, the injured worker's working diagnoses are L4 - S1 disc degeneration; L4 - L5 left; L4 - S1 mild lateral recess stenosis; L4 - S1 facet arthropathy; left leg radiculopathy versus pseudo-radiculopathy due to facet arthropathy; and chronic lumbago. According to an April 15, 2015 progress notes, the treating provider requested a left L4 - L5 and L5 - S1 laminotomy and foraminotomy and right-sided L4 - L5 laminotomy and foraminotomy with intraoperative spinal cord monitoring. The

LSO back brace and cold therapy unit 30-day rental are indicated based on whether the surgery is clinically indicated, medically necessary and approved. The documentation in the medical record does not contain a subsequent progress note (to the April 15, 2015 progress note). There is no documentation indicating whether the surgery was approved. Additionally, postoperative continuous flow cryotherapy use maybe for up to 7 days, including home use. The treating provider requested 30 days. 30 days is not clinically indicated or medically necessary. This review presumes that the surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. This request is not medically necessary.

Pneumatic Intermittent Compression Device: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation
http://www.aetna.com/cpb/medical/data/500_599/0500.html.

Decision rationale: Pursuant to the Aetna Clinical Policy Bulletin, Pneumatic Intermittent Compression Device is not medically necessary. Aetna considers full-leg or half-leg pneumatic compression devices for home use medically necessary durable medical equipment (DME) for the treatment of chronic venous insufficiency of the legs of members who have venous stasis ulcers that have me failed to heal after a 6-month trial of conservative therapy directed by the treating physician. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressings for the wound, exercise, and elevation of the limb. Aetna considers intermittent pneumatic compression devices of the lower extremities medically necessary DME to stimulate circulation and reduce the chances of deep venous thromboses for members who are unable to walk or bedridden due to trauma, orthopedic surgery, neurosurgery or other circumstances preventing ambulation. In this case, the injured worker's working diagnoses are L4 - S1 disc degeneration; L4 - L5 left; L4 - S1 mild lateral recess stenosis; L4 - S1 facet arthropathy; left leg radiculopathy versus pseudo-radiculopathy due to facet arthropathy; and chronic lumbago. According to an April 15, 2015 progress notes, the treating provider requested a left L4 - L5 and L5 - S1 laminotomy and foraminotomy and right-sided L4 - L5 laminotomy and foraminotomy with intraoperative spinal cord monitoring. The LSO back brace and cold therapy unit 30-day rental are indicated based on whether the surgery is clinically indicated, medically necessary and approved. The documentation in the medical record does not contain a subsequent progress note (to the April 15, 2015 progress note). There is no documentation indicating whether the requested surgery was approved. This review presumes that the surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. This request is not medically necessary.