

Case Number:	CM13-0027277		
Date Assigned:	12/11/2013	Date of Injury:	02/05/2009
Decision Date:	01/23/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	09/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, and is licensed to practice in Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 51-year-old female with a reported date of injury on 02/05/2009. The patient was status post posterior foraminotomy at L4-5 and L5-S1. The patient resented with 2+ lumbar paraspinous muscle spasm, the patient's incision was healing well, and there were no signs of infection. The patient had 5/5 motor strength in all muscles groups of the bilateral lower extremities. The patient had a negative straight leg raise bilaterally, and the patient's deep tendon reflexes were equal and symmetric at the knees and ankles. The patient had diagnoses included status post posterior foraminotomy at L4-5 and L5-S1 and superficial wound infection, healed. The physician's treatment plan included request for purchase of TENS unit, hot/cold therapy unit, front wheeled walker, 3-1 commode, and a home health nurse daily for 14 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: The California MTUS guidelines recommend the use of TENS patients with neuropathic pain, CRPS II, Phantom limb pain, spasticity, and multiple sclerosis. The guidelines note criteria for the use of TENS include; chronic intractable pain (for the conditions noted above), documentation of pain of at least three months duration; there is evidence that other appropriate pain modalities have been tried (including medication) and failed; a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; other ongoing pain treatment should also be documented during the trial period including medication usage; and a treatment plan including the specific short- and long-term goals of treatment. Within the provided documentation, it was unclear if the patient had undergone a 1 month in-home TENS trial, with documented efficacy of the trial. Additionally, it was unclear if the TENS unit would be used in conjunction with an active physical therapy modality. Therefore, the request for purchase of TENS unit is neither medically necessary nor appropriate.

Hot/cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back and shoulder, Cold/heat packs and continuous-flow cryotherapy.

Decision rationale: The California MTUS guidelines do not address heat/cold therapy. ACEOM recommends at-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold. The Official Disability Guidelines note cold and heat packs are recommended as an option for acute pain; at-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be 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 usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Per the provided documentation, the patient underwent a posterior foraminotomy at L4-5 and L5-S1 in 10/2013. The guidelines recommend the use of cryotherapy for postsurgical patients for use up to 7 days postsurgically including home use. Within the provided documentation, the requesting physician's rationale for the request was unclear. Therefore, the request for hot/cold therapy unit is neither medically necessary nor appropriate.

Front wheel walker: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Knee and Leg Procedure Summary.

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, Walking aids (canes, crutches, braces, orthoses & walkers).

Decision rationale: The California MTUS guidelines and ACOEM do not address the use of four wheeled walkers. The Official Disability Guidelines note almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. Assistive devices for ambulation can reduce pain associated with osteoarthritis. Frames or wheeled walkers are preferable for patients with bilateral disease. Within the provided documentation, the requesting physician's rationale for the request was unclear. It was unclear if the patient was unable to walk without the use of an ambulatory aid. Therefore, the request for a front wheel walker is neither medically necessary nor appropriate.

3-1 commode: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Knee and Leg Procedure.

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, durable medical equipment.

Decision rationale: The California MTUS guidelines and ACOEM do not address. The Official Disability Guidelines note durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. The guidelines note the term DME is defined as equipment which: can withstand repeated use, i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; & is appropriate for use in a patient's home. The guidelines note most bathroom and toilet items do not customarily serve a medical purpose and are primarily used for convenience in the home. Additionally, the requesting physician's rationale for the request is unclear within the provided documentation. Therefore, the request for a 3-1 commode is neither medically necessary nor appropriate.

Home health nurse daily for 14 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: The California MTUS guidelines note home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Within the provided documentation, the requesting physician's rationale for the request is unclear. Additionally, within the provided documentation, there was no documentation indicating the home health's nurse role in duties in the home during the 14 day requested period. Therefore, the request for home health nurse daily for 14 days is neither medically necessary nor appropriate.