

<b>Case Number:</b>	CM13-0037246		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	03/25/2011
<b>Decision Date:</b>	01/29/2014	<b>UR Denial Date:</b>	09/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	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, has a subspecialty in 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.

### 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 33-year-old female who reported an injury on 03/25/2011. The mechanism of injury was not provided for review. The patient underwent an MRI that revealed a 16 mm disc herniation with complete obliteration of the neural foramen at the L4-5 and compression of all nerve roots in that area. The patient's most recent physical exam findings included paravertebral muscle tenderness and spasm of the lumbar spine, significantly reduced range of motion, bilateral ankle dorsiflexion and EHLs rated at a 4/5, and reduced sensation in the bilateral L5 dermatomal distribution. Surgical intervention was recommended. The patient's diagnoses included lumbar radiculopathy, anxiety reaction, sleep disorder, and gastropathy. The patient's treatment plan included a sleep study, evaluation of an internist, and durable medical equipment to assist with postsurgical care.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Consult with internist:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The requested consultation with an internist is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is diagnosed with gastropathy. However, there is no clinical evaluation to support that

diagnosis. American College of Occupational and Environmental Medicine recommends consultation of a specialist when expertise is needed to assist with determining a patient's treatment plan. As the clinical documentation submitted for review does not provide any evidence of persistent gastrointestinal symptoms that would require further evaluation, the requested consultation with an internal medicine physician would not be supported. As such, the requested consult with internist is not medically necessary or appropriate.

**Front wheel walker:** Upheld

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

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

**Decision rationale:** The request for a front-wheeled walker is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is a surgical candidate for a lumbar fusion. However, anticipated ambulation issues are not sufficiently addressed to determine the needed for assisted ambulation. Additionally, there is no documentation that lower levels of equipment such as a regular cane or a regular walker could not sufficiently resolve any anticipated ambulation issues. As such, the requested front wheeled walker is not medically necessary or appropriate.

**Bath chair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention.

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

**Decision rationale:** The requested bath chair is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient is a surgical candidate for lumbar spinal fusion. Official Disability Guidelines state, "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 not considered primarily medical in nature." The clinical documentation submitted for review does not provide any evidence that the patient will have deficits limiting her ability to sit or stand in a shower. This request would be considered environmental in nature; and therefore, would not be supported as medically necessary. As such, the requested bath chair is not medically necessary or appropriate.

**Hand held shower head:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention.

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

**Decision rationale:** The requested hand held shower head is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient is a surgical candidate for lumbar spinal fusion. Official Disability Guidelines state, "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 not considered primarily medical in nature." The clinical documentation submitted for review does not provide any evidence that the patient will have deficits limiting her ability to sit or stand in a shower. This request would be considered environmental in nature; and therefore, would not be supported as medically necessary. As such, the requested hand held shower head is not medically necessary or appropriate.

**Sleep study:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Sleep Medicine (AASM) Guidelines

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

**Decision rationale:** The requested sleep study is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is diagnosed with a sleep disorder with an undetermined etiology. However, clinical assessment of the patient's sleep hygiene and failure to respond to pharmacological and nonpharmacological treatments is not documented. Also, psychiatric etiology has not been excluded. Official Disability Guidelines recommend polysomnograms for patients who have insomnia complaints for at least 6 months that are unresponsive to behavioral intervention and pharmacological interventions, and when psychiatric etiology has been excluded. As there is no documentation that this criterion has been met, a sleep study would not be indicated at this time. As such, the requested sleep study is not medically necessary or appropriate.