

Case Number:	CM14-0105147		
Date Assigned:	09/24/2014	Date of Injury:	09/20/2012
Decision Date:	10/24/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/07/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/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:

This is a 40-year-old male with a 9/20/12 date of injury. He injured his back when he grabbed a ladder from his van. According to a progress report dated 6/4/14, the patient continued to complain of pain in his back, which radiated to his right lower extremity. The provider is requesting revision decompression at bilateral L5-S1, posterolateral fusion using rigid segmental internal fixation and anterior lumbar interbody fusion at L5-S1. He has requested the post-operative use of a TLSO brace to protect and stabilize the spine, a front-wheeled walker to aid in ambulation, and a 3 in 1 commode. Objective findings: patient can flex up to 35 and extend to 20 degrees, straight leg raise is positive on the right, right extensor hallucis long strength is 4/5, sensory deficit in the right L5 and S1 dermatomes. Diagnostic impression: status post right-sided L5-S1 discectomy 8/22/13, recurrent right-sided L5-S1 disc herniation with instability. Treatment to date: medication management, activity modification, physical therapy, surgery. A UR decision dated 6/27/14 denied the requests for 3 in 1 commode, TLSO brace, and front-wheeled walker. While post-operative durable medical equipment may be considered, the requested surgery must be duly authorized as deeming appropriate and necessary in which the medical records submitted failed to support this yet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase or rental of 3 in one Commode between 6/26/2014 and 08/10/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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: CA MTUS does not address this issue. 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. Certain DME toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. The provider has requested a 3 in 1 commode for post-operative use. However, the reports provided for review do not document whether or not the initial surgical request has been approved. As a result, this associated post-surgical request cannot be substantiated. Therefore, the request for Purchase or rental of 3 in one Commode between 6/26/2014 and 08/10/2014 was not medically necessary.

Purchase or rental of TLSO (Thoraco-Lumbo-Sacral Orthosis) Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, Chronic Pain Treatment Guidelines 9792.23.5 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

Decision rationale: CA MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief, however, ODG states that lumbar supports are not recommended for prevention; as there is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. They are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP as a conservative option. The provider has requested a TLSO brace to protect and stabilize the spine post-operatively. However, the reports provided for review do not document whether or not the initial surgical request has been approved. As a result, this associated post-surgical request cannot be substantiated. Therefore, the request for Purchase or rental of TLSO (Thoraco-Lumbo-Sacral Orthosis) Brace was not medically necessary.

Purchase or rental of Front wheeled walker: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

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 Other Medical Treatment Guideline or Medical Evidence: Medicare National Coverage Determinations Manual

Decision rationale: CA MTUS does not address this issue. ODG states that walking aids are recommended. In addition, the Medicare National Coverage Determinations Manual states that Mobility Assistive Equipment is reasonable and necessary for personal mobility deficits sufficient to impair participation in mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home. It is noted that the provider has requested the post-operative use of a front-wheel walker to aid in ambulation, increase strength, and manage postoperative pain. However, the reports provided for review do not document whether or not the initial surgical request has been approved. As a result, this associated post-surgical request cannot be substantiated. Therefore, the request for Purchase or rental of Front wheeled walker was not medically necessary.