

<b>Case Number:</b>	CM14-0051942		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	07/30/2012
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	03/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/18/2014

### 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 Orthopedic Surgery 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:

Patient is a 58-year-old male who has submitted a claim for lumbar spinal stenosis without neurogenic claudication and disorders of the sacrum associated with an industrial injury date of 7/30/2012. Medical records from 2013 to 2014 were reviewed. Patient complained of constant low back pain radiating to the right lower extremity, associated with numbness and tingling sensation. Pain was rated 7-9/10 in severity. Aggravating factors included prolonged sitting, standing, and walking. He likewise had frequent constipation and urinary frequency. Physical examination of the lumbar spine showed muscle spasm and restricted range of motion. Straight leg raise test and femoral stretch test were positive bilaterally. Patient had severe positive tension signs. Patient was unable to get up from a squatting position without using his upper extremities. Motor strength of L2 to S1 myotomes was rated 3 to 4/5 bilaterally. Reflexes were absent at the patella and Achilles bilaterally. MRI of the lumbar spine, dated 11/2/2013, demonstrated diffuse disc herniation causing stenosis of the spinal canal and bilateral lateral recess with contact of the bilateral L4 transiting nerve roots at L3 to L4. Treatment to date has included lumbar epidural steroid injection, cortisone injections of the right hip, hot/cold modality, back brace, use of a TENS unit, acupuncture, use of a cane, extracorporeal shock wave therapy, and medications. Utilization review from 3/21/2014 denied the requests for lumbar orthotic brace, front wheeled walker, cold old, hospital bed for rental, home health evaluation, transportation, and [REDACTED] nursing services because the requested surgical procedure (wide decompression and fusion at L3 through the sacrum through a 360 degree technique using femoral allograft anteriorly, internal fixation anteriorly, and pedicle screws posteriorly with intertransverse fusion, as well as posterior decompression at L1 to L2) was not certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Orthotic 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Back Brace, Post-operative (Fusion).

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Low Back Section was used instead. It states that, back brace for postoperative use is under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace. There is no scientific information on the benefit of bracing for improving fusion rates or clinical outcomes following instrumented lumbar fusion. Mobilization after instrumented fusion is logically better for health of adjacent segments, and routine use of back braces is harmful to this principle. In this case, back brace was requested for postoperative use. Surgical plan is wide decompression and fusion at L3 through the sacrum through a 360 degree technique using femoral allograft anteriorly, internal fixation anteriorly, and pedicle screws posteriorly with intertransverse fusion, as well as posterior decompression at L1 to L2. However, utilization review from 3/21/2014 did not certify the request because patient was advised to discontinue smoking for 6 weeks prior to surgery. Moreover, a psychosocial evaluation is pending. There is no clear indication for certifying back brace at this time. Therefore, the request for lumbar orthotic brace is not medically necessary.

**Front Wheeled Walker:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chapter for Knee.

**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 Section, Walking aids.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee and Leg Section was used instead. It states that disability, pain, and age-related impairments seem to determine the need for a walking aid, i.e., walker. Frames or wheeled walkers are preferable for patients with bilateral disease. In this case, a walker was requested for postoperative use. Surgical plan is wide decompression and fusion at L3 through the sacrum through a 360 degree technique using femoral allograft anteriorly, internal fixation anteriorly, and pedicle screws posteriorly with

intertransverse fusion, as well as posterior decompression at L1 to L2. However, utilization review from 3/21/2014 did not certify the request because patient was advised to discontinue smoking for 6 weeks prior to surgery. Moreover, a psychosocial evaluation is pending. There is no clear indication for certifying a walking aid at this time. Therefore, the request for front-wheeled walker is not medically necessary.

**Commode:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 Section, Durable Medical Equipment.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee and Leg Section was used instead. It states that durable medical equipment (DME) is recommended generally if there is a medical need or purpose, is appropriate for home use, is generally not useful to a person in the absence of illness, and can withstand repeated use. Most bathroom and toilet supplies, i.e. commodes, do not customarily serve a medical purpose and are primarily used for convenience in the home. Certain DME toilet items (commodes) are medically necessary if the patient is bed- or room-confined. Environmental modifications are considered not primarily medical in nature. In this case, a commode was requested for postoperative use. Surgical plan is wide decompression and fusion at L3 through the sacrum through a 360 degree technique using femoral allograft anteriorly, internal fixation anteriorly, and pedicle screws posteriorly with intertransverse fusion, as well as posterior decompression at L1 to L2. However, utilization review from 3/21/2014 did not certify the request because patient was advised to discontinue smoking for 6 weeks prior to surgery. Moreover, a psychosocial evaluation is pending. There is no clear indication for certifying a DME at this time. Therefore, the request for commode is not medically necessary.

**Hospital Bed Rental x 30 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=227&ncdver=1&DocID=280.7&SearchType=advanced&bc=IAAAABAAA&AAAA&>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medicare National Coverage Determinations Manual.

**Decision rationale:** The CA MTUS and ODG do not specifically address the topic on hospital bed. Per the Strength of Evidence hierarchy established by the California Department of

Industrial Relations, Division of Workers' Compensation, the Medicare National Coverage Determinations Manual was used instead. It states that the criteria for a hospital bed include documentation that the patient's condition requires positioning of the body (e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections) in ways not feasible in an ordinary bed or that the patient's condition requires special attachments that cannot be fixed and used on an ordinary bed. In this case, a hospital bed was requested for postoperative use. Surgical plan is wide decompression and fusion at L3 through the sacrum through a 360 degree technique using femoral allograft anteriorly, internal fixation anteriorly, and pedicle screws posteriorly with intertransverse fusion, as well as posterior decompression at L1 to L2. However, utilization review from 3/21/2014 did not certify the request because patient was advised to discontinue smoking for 6 weeks prior to surgery. Moreover, a psychosocial evaluation is pending. There is no clear indication at this time. Therefore, the request for hospital bed rental x 30 days is not medically necessary.

**Home Health Evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (updated 03/18/2014).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

**Decision rationale:** As stated on page 51 of CA MTUS Chronic Pain Medical Treatment Guidelines, home health services are only recommended for otherwise recommended medical treatment for patients who are homebound, 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. In this case, a home health evaluation was requested for postoperative period. Surgical plan is wide decompression and fusion at L3 through the sacrum through a 360 degree technique using femoral allograft anteriorly, internal fixation anteriorly, and pedicle screws posteriorly with intertransverse fusion, as well as posterior decompression at L1 to L2. However, utilization review from 3/21/2014 did not certify the request because patient was advised to discontinue smoking for 6 weeks prior to surgery. Moreover, a psychosocial evaluation is pending. There is no clear indication for certifying home evaluation at this time. Therefore, the request for home health evaluation is not medically necessary.

**Transportation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg (updated 01/20/2014).

**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, Transportation (To and From Appointments).

**Decision rationale:** CA MTUS does not specifically address transportation. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that transportation is recommended for medically necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. In this case, transportation was requested for postoperative use. Surgical plan is wide decompression and fusion at L3 through the sacrum through a 360 degree technique using femoral allograft anteriorly, internal fixation anteriorly, and pedicle screws posteriorly with intertransverse fusion, as well as posterior decompression at L1 to L2. However, utilization review from 3/21/2014 did not certify the request because patient was advised to discontinue smoking for 6 weeks prior to surgery. Moreover, a psychosocial evaluation is pending. There is no clear indication for certifying transportation at this time. Therefore, the request for transportation is not medically necessary.

■■■ **Nursing Services:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (updated 03/18/2014).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

**Decision rationale:** As stated on page 51 of CA MTUS Chronic Pain Medical Treatment Guidelines, home health services are only recommended for otherwise recommended medical treatment for patients who are homebound, 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. In this case, nursing services were requested for postoperative period. Surgical plan is wide decompression and fusion at L3 through the sacrum through a 360 degree technique using femoral allograft anteriorly, internal fixation anteriorly, and pedicle screws posteriorly with intertransverse fusion, as well as posterior decompression at L1 to L2. However, utilization review from 3/21/2014 did not certify the request because patient was advised to discontinue smoking for 6 weeks prior to surgery. Moreover, a psychosocial evaluation is pending. There is no clear indication for certifying nursing services at this time. Therefore, the request for ■■■ nursing services is not medically necessary.