

Case Number:	CM14-0060172		
Date Assigned:	07/09/2014	Date of Injury:	10/29/2013
Decision Date:	08/22/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	05/01/2014

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 Neurological 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:

The records presented for review indicate that this 39 year-old individual was reportedly injured on 10/29/2013. The mechanism of injury is noted as a fall. The most recent progress note, dated 1/22/2014 indicates that there are ongoing complaints of low back, right shoulder, and left knee pain. The physical examination demonstrated lumbar spine: positive tenderness to palpation paraspinal region on the left, and midline of the lumbar spine. There was no spasm noted. The examination demonstrated absent left ankle reflex, decreased sensation left lower extremity along S1 distribution positive tenderness palpation to the facet joint and positive straight leg test with associated low back pain in supine at 50 degrees on the left, and 80 degrees while sitting. Bilateral knees: unremarkable exam. Diagnostic imaging studies include an MRI lumbar spine dated 1/10/2014 that reveals C3-C4 central disc protrusion. MRI lumbar spine performed on the same date reveals L2-L3, and L3-L4, disc bulge which produces mild bilateral neural foraminal narrowing. L4-L5, and L5-S1 disc bulge with bilateral facet arthrosis, and neural foraminal narrowing. Previous treatment includes medication, and conservative treatment. A request had been made for 3 in 1 commode, lumbosacral orthosis (LSO) back brace, bone growth stimulator, front wheelchair, and was not certified in the pre-authorization process on 4/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 in 1 commode: 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) Knee & Leg (Acute & Chronic) walking aids.

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 (Acute & Chronic) walking aids, updated 6/5/2014.

Decision rationale: 3 in 1 commode is not recommended for use in a young, healthy postsurgical patient. 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. After review of the medical documentation provided I was unable to identify any physical issues that would limit the injured workers ability to ambulate to the bathroom. Therefore, this request is deemed not medically necessary.

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: Low Back - Back brace, post operative (fusion).

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

Decision rationale: ACOEM treatment guidelines do not support the use of a lumbosacral orthosis (LSO) or other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis with flexion or extension plain radiographs of the lumbar spine. It is noted the patient has been recommended for a lumbar discectomy, but after review of the medical records provided there is no supporting documentation for the need of a back brace after this minimally invasive procedure. As such, this request is not considered medically necessary.

Bone Growth Stimulator: 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 - Bone Growth stimulators (BGS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Neck & Upper Back (Acute & Chronic) (updated 3/31/2014).

Decision rationale: California treatment guidelines support for the use of electrical bone growth stimulators in select clinical settings where evidence of prior non-union is noted, a grade 3 spondylolisthesis is present, or fusion is needed at more than one level. Additional criteria

include a current smoking habit, or diabetes/renal disease/alcoholism/or significant osteoporosis that is been demonstrated on x-rays. After review the medical documentation provided as well as the current treatment guidelines I was unable to identify any criteria on physical exam or in diagnostic studies that necessitated the use for a bone stimulator in the postoperative setting. Therefore, this request is deemed not medically necessary.

Front Wheel Chair: 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.

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 (Acute & Chronic) walking aids, updated 6/5/2014.

Decision rationale: A wheelchair is not recommended for use in a young, healthy postsurgical patient. 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. After review of the medical documentation provided I was unable to identify any physical issues that would limit the injured workers ability to ambulate postoperatively. Therefore, this request is deemed not medically necessary.