

Case Number:	CM14-0062963		
Date Assigned:	07/18/2014	Date of Injury:	07/16/2013
Decision Date:	10/08/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	05/05/2014

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:

Section 6: On 04/14/2014, the injured worker presented with complaints of low back pain with radiation into the bilateral posterior legs. He rated his pain 4/10 to 6/10. Section 7: His physical examination revealed normal sensation to the bilateral lower extremities, trace weakness in right ankle dorsiflexion, and a normal gait. Section 8: His medications were noted to include Anaprox, Norco, Nucynta, and Vicodin. Section 9: The treatment plan was noted to include a right L5 microdiscectomy due to his ongoing back and radiating leg pain from a disc herniation at L5-S1. Additionally, requests were submitted for a front wheel walker, a commode, a cold therapy unit, a pneumatic intermittent compression device, an LSO brace, medical preoperative clearance, an assistant surgeon, and an outpatient stay. The front wheel walker, pneumatic intermittent compression device, commode, and rental of a cold therapy unit were recommended to promote healing and improve function following the recommended surgery. Section 10: N/A Section 11: The Request for Authorization form was submitted on 04/14/2014. A 06/20/2014 followup note indicated that the injured worker had decided against the recommended surgery and would like to continue to pursue conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of DME-front wheel walker: 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 & leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: According to the Official Disability Guidelines, use of a framed or wheeled walker may be recommended to assist for ambulation for patients with pain in the bilateral lower extremities, usually due to bilateral knee conditions. The clinical information submitted for review indicated that a front wheeled walker was recommended to be used postoperatively after a recommended spinal surgery. However, updated documentation, specifically a 06/20/2014 clinical note, indicated that the injured worker had decided not to pursue surgical intervention. As he would not be undergoing surgery, the requested postoperative durable medical equipment would not be supported. As such, the request is not medically necessary.

Pneumatic intermittent compression device.: 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 & leg, Compression garments

Decision rationale: According to the Official Disability Guidelines, low levels of compression applied by stockings are effective in the prevention of edema and deep vein thrombosis. The clinical information submitted for review indicated that the injured worker had been recommended for a spinal surgery with use of a pneumatic intermittent compression device postoperatively. However, the Guidelines indicate that evidence shows low levels of compression applied by stockings are effective in the prevention of DVT. The injured worker was not specifically noted to have significant risk factors for postoperative DVT and there was not a clear rationale for the requested compression device over standard compression stockings. In the absence of further clarification regarding the need for the requested device, and as the injured worker was noted to have decided to not pursue surgical intervention, the requested pneumatic intermittent compression device to be used postoperatively is not supported. As such, the request 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 & leg, Durable medical equipment (DME).

Decision rationale: According to the Official Disability Guidelines, most bathroom and toilet supplies do not customarily serve a medical purpose, as they are primarily used for convenience in the home. Therefore, they are not considered durable medical equipment, which, by definition, is primarily and customarily used to serve a medical purpose. The clinical information submitted for review indicated that the commode was requested to be used postoperatively following the recommended lumbar surgery. However, the evidence based guidelines state that toilet supplies are not considered durable medical equipment, as they are not primarily used to serve a medical purpose. Therefore, the request is not supported. In addition, the documentation indicated that the injured worker had decided against the recommended surgery and wished to continue conservative treatment. Therefore, the requested postoperative care and supplies would also not be supported. For the reasons noted above, the request is not medically necessary.

Remaining 23 day rental of Cold Therapy unit.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability 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 & leg, Continuous-flow cryotherapy.

Decision rationale: According to the Official Disability Guidelines, use of a continuous flow cryotherapy unit is recommended for up to 7 days for postoperative use. The clinical information submitted for review indicated that the injured worker had previously been recommended for a lumbar surgery with use of a continuous flow cryotherapy unit for 30 days postoperatively. However, as the Guidelines specifically state that postoperative use is only recommended for 7 days, the request is not medically necessary. In addition, the more recent, 06/20/2014, followup note indicated that the injured worker had decided not to pursue surgical intervention at this time. Therefore, postoperative treatment and equipment is not indicated. For the reasons noted above, the request is not medically necessary.