

<b>Case Number:</b>	CM14-0074279		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	05/12/2008
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	04/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2014

### 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 Physical Medicine & Rehabilitation, Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 57-year-old male who reported an injury on 05/12/2008. During the course of his employment he was moving heavy furniture when he lifted a desk and experienced a sharp pain in the lower back. The injured worker had a history of lower back pain that radiated into the thigh and hips. The diagnoses included persistent back and right lower extremity pain, bilateral greater trochanteric bursitis, right hip arthrosis, right sacroiliac joint pain and right sided posterior superior iliac spine trigger point. The past surgeries included a decompression of the lumbar spine at the L4-S1 dated 04/2010 and a carpal tunnel release. The MRI dated 01/25/2014 of the lumbar spine revealed postoperative changes at the L5-S1 secondary to laminectomy and metal artifact, broad left foraminal bulge at the L5-S1, and a 4 mm bulge with moderate left greater than right neural foraminal stenosis at the L4-5. The past treatments included epidural steroid injection, psych eval, x-ray, acupuncture, and physical therapy times 1 year, and medication. The findings dated 04/02/2014 of the lumbar spine revealed a well healed incision. Lumbar paraspinals tender to touch with spasms, guarding was present. The flexion was 40 degrees and extension 20 degrees. Straight leg raise maneuver was positive on the right and negative to the left. The sensory deficits were present at the right at the L4, L5, and S1 dermatomes. The medications included Norco 7.5/325 mg with a rate of pain 7/10 with medication and 9/10 without medication. The treatment plan included pain management consult with possible pain pump, surgery, and followup in 4 to 6 weeks. The request for authorization dated 07/16/2014 was submitted with documentation. The rationale for the back brace, the front wheel walker, and a 3 in 1 commode was they were needed postoperatively for stabilizing the spine and to aid in ambulation to increase strength.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TLSO 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/BACK BRACE.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** The California MTUS/ACOEM guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to deconditioning of the spinal muscles. The objective findings were vague and did not address the lumbar region. The guidelines indicate that lumbar supports do not have any lasting benefit beyond the acute phase of symptom relief. As such, the request for a TLSO brace is not medically necessary and appropriate.

**FRONT WHEEL 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/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) Durable Medical Equipment.

**Decision rationale:** The California MTUS/ACOEM Guidelines recommend as indicated below. Almost half of patients with knee pain possess a walking aid. 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. There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. The clinical notes did not indicate that the injured worker needed an assistive device or that gait was independent. As such, the request for front wheel walker is not medically necessary.

**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/DME.

**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) Durable Medical Equipment.

**Decision rationale:** The Official Disability Guidelines indicate that most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. The term DME is defined as equipment which: Can withstand repeated use, i.e., could normally be rented, and used by successive patients; Is primarily and customarily used to serve a medical purpose; Generally is not useful to a person in the absence of illness or injury; & Is appropriate for use in a patient's home. The guidelines indicate that toilet supplies do not customarily serve a medical purpose and are used primarily for convenience. The durable medical equipment is normally rented and is generally not useful for a person in the absence of illness or injury. As such, the request for 3 in 1 commode is not medically necessary.