

<b>Case Number:</b>	CM14-0196606		
<b>Date Assigned:</b>	12/04/2014	<b>Date of Injury:</b>	08/09/2013
<b>Decision Date:</b>	03/09/2015	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 patient is a 58 year old male with an injury date on 08/09/2013. Based on the 10/07/2014 progress report provided by the treating physician, the diagnoses are:1. L4-5 and L5-S1 disc degeneration/displacement 2. L4-5 stenosis3. Left leg radiculopathy4. Right shoulder impingement syndromeAccording to this report, the patient complains of "continues to have right shoulder pain." Pain is a 6/10 with medications and an 8/10 without medications. The patient also complains of "continues to have lower back pain which radiates down the left lower extremity." Pain is a 5-6/10 with medications and a 6-9/10 without medications. Physical exam reveals tenderness of the paravertebral muscles, bilaterally. There is decrease sensation on the L4 and L5 dermatomes and to a lesser degree SI dermatome on the left. Lumbar range of motion is decreased. Straight leg raise is positive. "There is no gross deformity. There is no appreciable swelling or gross atrophy of the paravertebral muscles." Per treating physician, the patient "has failed physical therapy, injections, medications and life style modifications and will require L4-L5 laminotomy, subtotal facetectomy and foraminotomy."The treatment plan is awaiting for authorization for the right shoulder injection; request for L4-L5 laminotomy, subtotal facetectomy and foraminotomy with TLIF, PSIF at L4-L5 and L5-S1 with cage and instrumentation; pre-operative medical clearance; LSO brace, front wheeled walker, intermittent pneumatic compression device and post-operative physical therapy; refill medications; and follow up in four to six weeks. The patient is "Temporary Totally Disabled until Nov 16, 2014. There were no other significant findings noted on this report. The utilization review denied the request for 1 DME; Orthofix Bone Growth Stimulator, Lumbar LSO, Cold Therapy Unit,

Pneumatic Intermittent Compression Device, Front Wheel Walker & 3-1 Commode on 10/24/2014 based on the ODG guidelines. The requesting physician provided treatment reports from 05/27/2014 to 10/07/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **ORTHOFIX BONE GROWTH STIMULATOR: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Treatment, Integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic chapter, under Bone growth stimulators

**Decision rationale:** The patient presents with right shoulder pain rated 8/10 without medications, 6/10 with medications. Patient also complains of pain to the lower back which radiates down the left lower extremity rated 6-9/10 without medications, 5-6/10 with medications. Patient is status post lumbar ESI on 06/16/14. The request is for ORTHOFIX BONE GROWTH STIMULATOR. Physical examination dated 10/07/14 revealed tenderness to palpation of the lumbar paraspinal muscles bilaterally and decreased sensation on the L4, L5, and S1 dermatomes on the left side. The patient is currently prescribed Norco, Ativan, Omeprazole, Trazodone, Zanaflex, Dicyclomine, Lisinopril, Naproxen, and Nasonex. Diagnostic imaging reports were included of MRI of the lumbar spine dated 10/01/13, significant findings include: "Broad based disc bulge at L4-5 and L5-S1... Annular tears at L4-5 and L5-S1... L4-5 bilateral severe lateral recess stenosis..." Patient is temporarily totally disabled until 11/14/14. ODG Guidelines, Low Back - Lumbar & Thoracic chapter, under Bone growth stimulators states: "Under study. There is conflicting evidence, so case by case recommendations are necessary. Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases - e.g., revision pseudoarthrosis, instability, and smoker. There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at "high risk", but this has not been convincingly demonstrated. Criteria for use for invasive or non-invasive electrical bone growth stimulators: Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: 1. One or more previous failed spinal fusions; 2. Grade III or worse spondylolisthesis; 3. Fusion to be performed at more than one level; 4. Current smoking habit ; 5. Diabetes, Renal disease, Alcoholism; or 6. Significant osteoporosis which has been demonstrated on radiographs." In regards to the request for a bone growth stimulator prior to an upcoming laminotomy and lumbar spinal fusion, the requested device appears reasonable. While this patient does not present with any of the "high-risk" factors such as smoking, osteoporosis, diabetes, or renal disease, progress report dated 10/07/14 indicates that the patient is scheduled for a two level fusion - L4-L5 and L5-S1 - for which the use of a BGS system is deemed medically appropriate. Therefore, this request IS medically necessary.

## **Lumbar LSO: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Treatment, integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic)

**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) low back chapter, lumbar support

**Decision rationale:** The patient presents with right shoulder pain rated 8/10 without medications, 6/10 with medications. Patient also complains of pain to the lower back which radiates down the left lower extremity rated 6-9/10 without medications, 5-6/10 with medications. Patient is status post lumbar ESI on 06/16/14. The request is for LUMBAR LSO. Physical examination dated 10/07/14 revealed tenderness to palpation of the lumbar paraspinal muscles bilaterally and decreased sensation on the L4, L5, and S1 dermatomes on the left side. The patient is currently prescribed Norco, Ativan, Omeprazole, Trazodone, Zanaflex, Dicyclomine, Lisinopril, Naproxen, and Nasonex. Diagnostic imaging reports were included of MRI of the lumbar spine dated 10/01/13, significant findings include: "Broad based disc bulge at L4-5 and L5-S1... Annular tears at L4-5 and L5-S1... L4-5 bilateral severe lateral recess stenosis..." Patient is temporarily totally disabled until 11/14/14. ACOEM Guidelines page 301 on lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of the symptom relief." ODG Guidelines under its low back chapter, lumbar support states, "Prevention: Not recommended for prevention. There is strong, consistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment, ODG further states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and treatment for a nonspecific LBP (very low quality evidence, but may be a conservative option)." In regards to the request for a lumbar spine brace for the management of this patient's intractable chronic lower back pain, there is lack of support from the guidelines. The patient does not present with instability, spondylolisthesis, fractures, dislocation. However, the patient is scheduled for a 2-level fusion for which post-operative use of LSO may be an option. The request IS medically necessary.

## **Cold therapy unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Treatment, integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, under cold/heat packs

**Decision rationale:** The patient presents with right shoulder pain rated 8/10 without medications, 6/10 with medications. Patient also complains of pain to the lower back which

radiates down the left lower extremity rated 6-9/10 without medications, 5-6/10 with medications. Patient is status post lumbar ESI on 06/16/14. The request is for COLD THERAPY UNIT. Physical examination dated 10/07/14 revealed tenderness to palpation of the lumbar paraspinal muscles bilaterally and decreased sensation on the L4, L5, and S1 dermatomes on the left side. The patient is currently prescribed Norco, Ativan, Omeprazole, Trazodone, Zanaflex, Dicyclomine, Lisinopril, Naproxen, and Nasonex. Diagnostic imaging reports were included of MRI of the lumbar spine dated 10/01/13, significant findings include: "Broad based disc bulge at L4-5 and L5-S1... Annular tears at L4-5 and L5-S1... L4-5 bilateral severe lateral recess stenosis..." Patient is temporarily totally disabled until 11/14/14. ODG guidelines, Low Back - Lumbar & Thoracic, under cold/heat packs states: "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function." In regards to the request for a cold therapy unit, the request appears reasonable, however there is no specification of a duration of use. Cold therapy units are indicated for the management of acute pain, such as the immediate postoperative period, however it is not clear from the records provided whether the treater is requesting a purchase or a rental. In this case, a 7-day rental for the post-operative period would be appropriate, but without a clearer statement of intent to rent this unit the medical necessity cannot be substantiated. Therefore, this request IS NOT medically necessary.

### **Pneumatic Intermittent Compression Device: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Treatment, integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, DVT; The National Guidelines Clearinghouse

**Decision rationale:** The patient presents with right shoulder pain rated 8/10 without medications, 6/10 with medications. Patient also complains of pain to the lower back which radiates down the left lower extremity rated 6-9/10 without medications, 5-6/10 with medications. Patient is status post lumbar ESI on 06/16/14. The request is for PNEUMATIC INTERMITTENT COMPRESSION. Physical examination dated 10/07/14 revealed tenderness to palpation of the lumbar paraspinal muscles bilaterally and decreased sensation on the L4, L5, and S1 dermatomes on the left side. The patient is currently prescribed Norco, Ativan, Omeprazole, Trazodone, Zanaflex, Dicyclomine, Lisinopril, Naproxen, and Nasonex. Diagnostic imaging reports were included of MRI of the lumbar spine dated 10/01/13, significant findings include: "Broad based disc bulge at L4-5 and L5-S1... Annular tears at L4-5 and L5-S1... L4-5 bilateral severe lateral recess stenosis..." Patient is temporarily totally disabled until 11/14/14.

MTUS and ODG do not discuss pneumatic compression therapy for the lower back. ODG guidelines under Knee Chapter, DVT, does address post-operative treatments for DVT prophylaxis. The National Guidelines Clearinghouse also recommends "mechanical compression devices in the lower extremities are suggested in elective spinal surgery to decrease the incidence of thromboembolic complications." For duration of use, it recommends it from just prior to or at the beginning of surgery and continuation until the patient is fully ambulatory." In regards to the request for a pneumatic compression unit, the request appears reasonable. Pneumatic compression units are indicated for DVT prophylaxis during the immediate postoperative period, though it is not clear from the records provided whether the treater is requesting a purchase or a rental. That being said, guidelines do not provide a specific duration of use - only that such devices be used just prior to surgery until the patient is ambulatory again, a time period which varies from patient to patient. As the prevention of DVT is paramount in the post operative convalescent period, such a device appears reasonable. Therefore, this request IS medically necessary.

**Front wheel walker:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Treatment, integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic)

**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 chapter, walking aids - canes, crutches, braces, orthoses, and walkers

**Decision rationale:** The patient presents with right shoulder pain rated 8/10 without medications, 6/10 with medications. Patient also complains of pain to the lower back which radiates down the left lower extremity rated 6-9/10 without medications, 5-6/10 with medications. Patient is status post lumbar ESI on 06/16/14. The request is for FRONT WHEEL WALKER. Physical examination dated 10/07/14 revealed tenderness to palpation of the lumbar paraspinal muscles bilaterally and decreased sensation on the L4, L5, and S1 dermatomes on the left side. The patient is currently prescribed Norco, Ativan, Omeprazole, Trazodone, Zanaflex, Dicyclomine, Lisinopril, Naproxen, and Nasonex. Diagnostic imaging reports were included of MRI of the lumbar spine dated 10/01/13, significant findings include: "Broad based disc bulge at L4-5 and L5-S1... Annular tears at L4-5 and L5-S1... L4-5 bilateral severe lateral recess stenosis..." Patient is temporarily totally disabled until 11/14/14. MTUS and ODG guidelines, lower back chapter, does not specifically address the use of walkers, though the knee/leg chapter states the following about walking aids - canes, crutches, braces, orthoses, and walkers: "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." In regards to the request for a front wheel walker, the request appears reasonable. The patient is scheduled to undergo a two level spinal fusion and will likely experience significant pain and loss of function secondary to such a procedure. The restoration of ambulation in such patients is necessary to prevent non-use deterioration of the lower extremities and improve overall patient outcome. Therefore, the request IS medically necessary.

### **3 in 1 commode:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Treatment, integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic)

**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 chapter, DME

**Decision rationale:** The patient presents with right shoulder pain rated 8/10 without medications, 6/10 with medications. Patient also complains of pain to the lower back which radiates down the left lower extremity rated 6-9/10 without medications, 5-6/10 with medications. Patient is status post lumbar ESI on 06/16/14. The request is for 3-1 COMMODORE. Physical examination dated 10/07/14 revealed tenderness to palpation of the lumbar paraspinal muscles bilaterally and decreased sensation on the L4, L5, and S1 dermatomes on the left side. The patient is currently prescribed Norco, Ativan, Omeprazole, Trazodone, Zanaflex, Dicyclomine, Lisinopril, Naproxen, and Nasonex. Diagnostic imaging reports were included of MRI of the lumbar spine dated 10/01/13, significant findings include: "Broad based disc bulge at L4-5 and L5-S1... Annular tears at L4-5 and L5-S1... L4-5 bilateral severe lateral recess stenosis..." Patient is temporarily totally disabled until 11/14/14. Under durable medical equipment section in ODG Guidelines "durable medical equipment is defined as an equipment that is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. 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." In regards to the request for a 3 in 1 commode - presumably for patient use in the home postoperatively. The request IS medically necessary.