

Case Number:	CM14-0198951		
Date Assigned:	12/09/2014	Date of Injury:	04/22/2009
Decision Date:	01/26/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/26/2014

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 Rehab, has a subspecialty in Pain Medicine 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:

This is a male patient with a date of injury of April 22, 2009. A utilization review determination dated November 4, 2014 recommends non-certification of a commode (bedside 3-in-1), shower chair, and an inpatient hospital stay day #4. A progress note dated September 19, 2014 identifies subjective complaints of continued low back pain with radiation into lower extremities with numbness in the right foot. The patient reports constant shooting to the right lower extremity, has difficulty with walking and standing for more than 10 minutes, numbness in bilateral hands, and cervicgia. The patient's current pain level is a 7/10. The patient describes his pain as shooting, aching, throbbing, and he has numbness in the right lower extremity. The physical examination identifies pain with range of motion of the cervical spine at the end of all planes, palpable cervicothoracic and lumbar paraspinal muscle spasm with myofascial trigger points and twitch response with referral of pain, the patient ambulates with a single point walking cane, range of motion of the lumbar spine is limited by pain to 45 with forward flexion, extension is to neutral, right lateral flexion is at 20 and left lateral flexion is at 15, and straight leg raise test is positive on the right at 60 and at 70 on the left. The diagnoses include one-year status posts transacral lumbar fusion complicated by hardware perforation of viscous and subsequent wound infection and peritonitis, lumbar degenerative disc disease and lumbar radiculopathy, cervicgia, cervical degenerative disc disease and right upper extremity radiculopathy, and significant depression. The treatment plan recommends a prescription for Norco 10/325, #90, a prescription for Zanaflex 4 mg, #60, prescription for Voltaren gel 1g, #5 tubes, prescription for Lidoderm patches 5%, #60, continue with physical therapy, continuous follow-up with psychiatry, and continue to follow-up regarding tinnitus. An operative report dated October 24, 2014 identifies that the patient underwent an L4-5 and L5-S1 laminectomy. An inpatient progress note for post day #4 dated October 26, 2014 identifies that patient is feeling well and is ambulatory. The treatment

plan identifies that the patient is doing clinically well. A physical therapy note dated October 26, 2014 does not identify any need for discharge equipment or any further therapy needs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Commode (bedside 3-in-1): 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), Durable Medical Equipment

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: Regarding the request for a 3-in-1 commode, California MTUS does not address the issue. ODG states certain DME (durable medical equipment) toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. Within the documentation available for review, there is no documentation that the patient is bed or room-confined. In the absence of such documentation, the currently requested 3-in-1 commode is not medically necessary.

Shower 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 (ODG), Durable Medical Equipment

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: Regarding the request for a shower chair, California MTUS does not address the issue. ODG states certain DME toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. Within the documentation available for review, there is no documented reason to recommend a shower chair. In the absence of such documentation, the currently requested shower chair is not medically necessary.

Retrospective request for Inpatient hospital stay day #4 (DOS: 10/26/14): 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), Hospital length of stay (LOS)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Hospital Length of Stay (LOS); Low Back Chapter, Hospital Length of Stay (LOS).

Decision rationale: Regarding the request for an inpatient hospital stay day #4, MTUS does not address the issue. ODG recommends the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. For prospective management of cases, median is a better choice than mean (or average) because it represents the mid-point, at which half of the cases are less, and half are more. For retrospective benchmarking of a series of cases, mean may be a better choice because of the effect of outliers on the average length of stay. For lumbar laminectomies, the recommendation is median 2 days and the mean 3.5 days. Within the documentation available for review, it is indicated that the patient is status post a lumbar laminectomy and there is no medical reason or indication why the patient requires a day #4 inpatient hospital stay. In the absence of such documentation, the currently requested inpatient hospital stay day #4 is not medically necessary.