

<b>Case Number:</b>	CM14-0202519		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	11/10/2012
<b>Decision Date:</b>	01/30/2015	<b>UR Denial Date:</b>	10/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2014

### 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 Family Practice 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 47 year old male sustained a work related injury on 11/10/2012. The mechanism of injury was not made known. A prescription form dated 09/11/2014 requesting a four wheeled walker was submitted for review. The indication section relating to medical necessity was left blank. A progress note dated 09/11/2014 was partially illegible. Diagnoses included reflex sympathetic dystrophy lower limb, radiculitis/neuritis thoracic or lumbar and AVP L5-S1. Treatment plan included a four wheeled walker. A written prescription dated 09/19/2014 and submitted for review was for a four wheeled walker, 3 in 1 commode, back brace and cold therapy unit. Diagnosis included HNP at L5-S1 and low back pain. According to an operative report dated 10/13/2014, the injured worker underwent a laminectomy L5-S1 and nerve root decompression left L5-S1. A physical therapy evaluation dated 10/14/2014 noted that the injured worker required moderate assistance with mobility and was limited by back pain, left leg pain and dizziness and would benefit from physical therapy treatment to promote independence and safety with functional mobility. According to a hospital discharge summary following surgery and dated 10/17/2014, the preoperative level of pain had decreased significantly and the injured worker remained neurologically intact. Once ambulating independently and tolerating oral medication for pain, he was discharged. Discharge instructions included no heavy lifting, no prolonged sitting, keep wound clean and dry and follow up in one week. A progress report dated 10/23/2014 noted that the injured worker had two separate problems. One was stenosis in his low back that had been decompressed and left leg RSD. He had a double crush syndrome. Sympathetic blocks were requested. Diagnoses included L5-S1 laminectomy and left leg RSD. The treatment plan included continuing home walking program, sympathetic block and Tramadol. A pain management agreement was signed. According to a pain management follow up dated 10/27/2014 the injured worker presented with left foot and lower extremity pain that

was described as constant and severe. It was worse with prolonged standing and walking and was partially better with rest and medications. He complained of burning, sensitivity, discoloration and cold sensation. He also developed right buttock pain from piriformis pain syndrome as a result of altered gait due to the RSD of the left lower extremity. On 10/31/2014, Utilization Review non-certified the request for the purchase of a three-in-one commode, purchase of a cold therapy unit, purchase of a four wheel walker and purchase of a lumbar back brace. The request was received on 10/28/2014. According to the Utilization Review physician, a postoperative evaluation of the patient with objective evidence of functional deficits that warrant the requested durable medical equipment was not included in the submitted records. There was no report of gait abnormality or difficulty with ambulation to warrant the requested walker. Use of a corset for treatment is not recommended by ACOEM guidelines. In regards to the request for a commode, guidelines state that most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. It further states that medical conditions that result in physical limitation 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 cold therapy unit, guidelines state that postoperative use generally may be up to 7 days, including home use. There was no clear indication for purchase of the unit and use beyond the duration recommended in the guidelines. The decision was appealed for an Independent Medical Review.

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

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

**Purchase of a three-in-one commode:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) DME-Knee and Medicare Guidelines for commode

**Decision rationale:** According to the guidelines a DME product is appropriate as deemed by Medicare necessity. The ODG and ACOEM guidelines do not specifically comment on a commode. A commode is appropriate when the claimant is unable to utilize regular toilet facilities. In this case, there is no indication of indefinite inability to use a regular bathroom. Therefore, the purchase of a commode for long term use is not medically necessary.

**Purchase of a cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) cold packs.

**Decision rationale:** Cold therapy units may be appropriate in the first few days for an acute complaint or intervention for back pain. Per guidelines, Continuous flow of cryotherapy maybe use up to seven days out from surgery. There is no indication for long-term use and therefore the purchase of a cold therapy is not medically necessary.

**Purchase of a four wheel walker:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints.

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

**Decision rationale:** According to the guidelines, walkers are recommended for those with bilateral knee pain and osteoarthritis. Assistive devices can reduce pain. Disability and age related impairments determine the need for a walking aid. In this case, the claimant had lumbar pain which had improved after surgery. There is no indication for indefinite use of a walker. Therefore the purchase of a walker is not justified and not medically necessary.

**Purchase of a lumbar back brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** According to the ACOEM guidelines, lumbar supports have not been shown to provide lasting benefit beyond the acute phase of symptom relief. In this case, the claimant's injury was remote and symptoms were chronic. The use of a back brace is not medically necessary.