

Case Number:	CM15-0003515		
Date Assigned:	02/20/2015	Date of Injury:	11/26/2012
Decision Date:	04/06/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/07/2015

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 injured worker is a 52 year old male, who sustained an industrial injury on November 26, 2012. He reported a lifting injury. The diagnoses have included osteoarthritis, lesion of sciatic nerve and pain in limb. Treatment to date has included medication, diagnostic studies, and epidural steroid injections. Currently, the injured worker complains of low back pain and left leg pain which he rated an 8 on a 10-point scale. The injured worker had an abnormal toe/heel walk on the left lower extremity during examination and had tenderness to palpation in the lumbar paraspinous musculature on the left. Midline tenderness was noted and he had muscle spasm over the lumbar spine. His range of motion was limited and sensory testing revealed a decreased pin sensation in the foot dorsum. On December 22, 2014 Utilization Review non-certified a request for front wheel walker, three-in-one commode, and purchase of thoracolumbar sacral orthosis brace, noting that the guidelines recommend front wheeled walkers for patients with bilateral lower extremity disease, noting that the guidelines recommend commodes for bed or room confined patients and noting that thoracolumbar sacral orthotics are recommending following spinal fusions. The Official Disability Guidelines was cited. On January 7, 2015, the injured worker submitted an application for IMR for review of front wheel walker, three-in-one commode, and purchase of thoracolumbar sacral orthosis brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee and leg chapter, walking aids (canes, crutches, braces, othoses, and walkers).

Decision rationale: The patient presents with low back pain radiating to left lower extremity rated at 8/10. The request is for 1 FRONT WHEEL WALKER. The request for authorization was not provided. Patient also notes pain in the bilateral shoulders and arms rated at 7/10. Patient has failed three epidural injections. Patient reports calf pain with waking and leg cramping. Patient's gait is antalgic. Toe/heel walk is abnormal on the left. Muscle spasm is positive over the lumbar spine. Range of motion of the lumbar spine is decreased. Sciatic nerve compression is positive on the left. Patient's medications include Naproxen, Tramadol and Gabapentin cream. The patient is temporarily totally disabled. MTUS and ACOEM guidelines do not address this request; however, ODG guidelines on walking aids (canes, crutches, braces, othoses, and walkers) states that almost half of patients with knee pain possess a walking aid. Assistive devices for ambulation can reduce pain associated with osteoarthritis. Frames or wheeled walkers are preferable with bilateral disease. Per progress report dated 12/02/14, treater's reason for the request is "to aid in ambulation, increase strength and manage postoperative pain." Per progress report dated 11/04/14, treater is "recommending L4-5 left sided hemilaminotomy and discectomy." However, it is unknown if the request for surgery has been submitted, authorized or scheduled. The treater does not explain why a front wheel walker is needed for this relatively simple orthopedic surgery not requiring any period of immobility. The request IS NOT medically necessary.

1 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee and leg chapter, durable medical equipment.

Decision rationale: The patient presents with low back pain radiating to left lower extremity rated at 8/10. The request is for 1 3 IN 1 COMMODO. The request for authorization was not provided. Patient also notes pain in the bilateral shoulders and arms rated at 7/10. Patient has failed three epidural injections. Patient reports calf pain with waking and leg cramping. Patient's gait is antalgic. Toe/heel walk is abnormal on the left. Muscle spasm is positive over the lumbar spine. Range of motion of the lumbar spine is decreased. Sciatic nerve compression is positive on the left. Patient's medications include Naproxen, Tramadol and Gabapentin cream. The patient is temporarily totally disabled. 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. 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." Per progress report dated 12/02/14, treater's reason for the request is "to aid the patient in his recovery." Per progress report dated 11/04/14, treater is "recommending L4-5 left sided hemilaminotomy and discectomy. However, it is unknown if the request for surgery has been submitted or authorized. Furthermore, there is no discussion that the patient will be bed or room confined. Therefore, the request IS NOT medically necessary.

1 Purchase of thoracolumbar sacral orthosis 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic Chapter, lumbar supports.

Decision rationale: The patient presents with low back pain radiating to left lower extremity rated at 8/10. The request is for 1 PURCHASE OF THORACOLUMBAR SACRAL ORTHOSIS BRACE. The request for authorization was not provided. Patient also notes pain in the bilateral shoulders and arms rated at 7/10. Patient has failed three epidural injections. Patient reports calf pain with waking and leg cramping. Patient's gait is antalgic. Toe/heel walk is abnormal on the left. Muscle spasm is positive over the lumbar spine. Range of motion of the lumbar spine is decreased. Sciatic nerve compression is positive on the left. Patient's medications include Naproxen, Tramadol and Gabapentin cream. The patient is temporarily totally disabled. ACOEM guidelines page 301 on lumbar bracing state, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Low Back - Lumbar & Thoracic Chapter, lumbar supports topic, states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." For post-operative bracing, ODG states, "Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician." Per progress report dated 12/02/14, treater's reason for the request is "to protect and stabilize the spine, restrict range of motion, and manage postoperative pain." Per progress report dated 11/04/14, treater is "recommending L4-5 left sided hemilaminotomy and discectomy. However, it is unknown if the request for surgery has been submitted or authorized. Discectomy/laminectomy surgery does not result in instability of the spine requiring lumbar bracing. Furthermore, the patient has a chronic condition, and does not present with compression fracture, documented instability, or spondylolisthesis to warrant lumbar support based on guidelines. Therefore, the request IS NOT medically necessary.