

Case Number:	CM15-0192137		
Date Assigned:	10/06/2015	Date of Injury:	08/11/2008
Decision Date:	12/08/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	09/30/2015

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: Preventive Medicine, Occupational Medicine

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 36 year old male, who sustained an industrial injury on 8-11-2008. The medical records indicate that the injured worker is undergoing treatment for degeneration of thoracic-lumbar intervertebral disc; status post anterior lumbar decompression with interbody fusion L5-S1 (10-17-2014). According to the progress report dated 9-8-2015, the injured worker presented with continued complaints of lower back and stabbing pain in his bilateral legs. The level of pain is not rated. The physical examination of the lumbar spine was not indicated. Per notes, he is not currently using any pain medications. Previous diagnostic studies include MRI of the lumbar spine (3-27-2015). The treating physician describes the lumbar MRI as "evidence of anterior interbody fusion at L5-S1, no central canal or foraminal stenosis, and small centralized disc protrusion at L4-5". Treatments to date include medication management, sciatic notch injection on 8-11-2015 (no relief), and surgical intervention. Work status is described as no repetitive bending, stooping, or twisting. No lifting greater than 15 pounds. Limit sitting and walking to 30 minutes an hour. The treatment plan included posterior lumbar decompression laminectomy and facetectomy at L5-S1 with posterior lateral fixation and fusion, pre-op labs, cold therapy, back brace, front wheeled walker, and 3:1 commode. The original utilization review (9-17-2015) had non-certified a request for back brace, front wheeled walker, 3:1 commode, and cold therapy. Repeat surgery was not authorized.

IMR ISSUES, DECISIONS AND RATIONALES

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

Back brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Brace; post operative (fusion).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back/Braces.

Decision rationale: MTUS Guidelines address this issue only in the setting of acute low back strain. ODG Guidelines address this issue in additional detail and recommend bracing if there is a demonstrated instability and/or after fusion surgery. This individual does not fit these criteria. Several months post surgical he has a demonstrated stability and healing at the surgical sight and repeat surgery is not approved. Under these circumstances, the request for the low back brace is not supported by Guidelines and is not medically necessary.

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 (ODG), Chapter: Knee & Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee/DME and Other Medical Treatment Guidelines <https://www.medicare.gov/coverage/durable-medical-equipment-coverage.html>.

Decision rationale: MTUS Guidelines do not address this issue. The issue of DME equipment is discussed in detail in the Knee section of the ODG Guidelines. In addition, Medicare has published Guidelines that address this issue. The standard medical necessity criteria for DME equipment includes: Durable (long-lasting), used for a medical reason, not usually useful to someone who isn't sick or injured, and used in your home. All of these standards have not been met with this request. Without the surgery, there is no demonstrated need for the use of a front wheel walker. This individual is able to walk without demonstrated neurological deficits or severe gait deficits. Under the circumstances, the front wheel walker is not medically necessary and appropriate.

3;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 (ODG), Chapter: Knee & Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee/DME and Other Medical Treatment Guidelines <https://www.medicare.gov/coverage/durable-medical-equipment-coverage.html>.

Decision rationale: MTUS Guidelines do not address this issue. The issue of DME equipment is discussed in detail in the Knee section of the ODG Guidelines. In addition, Medicare has published Guidelines that address this issue. The standard medical necessity criteria for DME equipment includes: Durable (long-lasting), used for a medical reason, not usually useful to someone who isn't sick or injured, and used in your home. All of these standards have not been met with this request. Without surgery, there is not post-operative need for the 3:1 commode. The commode is not medically necessary and appropriate.

Cold therapy: 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), Chapter: Low Back, Cold/heat packs.

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/Cold-Heat Packs Shoulder/Continuous cooling units.

Decision rationale: MTUS Guidelines do not adequately address this issue. ODG Guidelines support the use of heat packs for chronic low back pain, cold cooling supported for acute low back pain. The Guidelines address the issue of continuous cooling the shoulder section. Continuous cooling is only supported in a post surgical setting and then for only up to 7 days post-operative. This individual does not meet these criteria. The request is directly related to surgery which is not recommended at this time. Under these circumstances, the Cold therapy is not medically necessary and appropriate.