

<b>Case Number:</b>	CM14-0218895		
<b>Date Assigned:</b>	01/08/2015	<b>Date of Injury:</b>	07/29/1997
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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 injured worker is a 40 year old male, who sustained an industrial injury on July 29, 1997. He has reported upper and lower back pain. The diagnoses have included thoracic spine pain, backache not otherwise specified, spinal cord injury not otherwise specified, Syringomyelia, anxiety, and depression. Treatment to date has included medications, physical therapy, acupuncture, and functional restorative therapy. X-ray of the spine revealed no evidence of fracture or subluxation. Currently, the IW complains of upper and lower back pain, and difficulty sleeping and walking. The treating physician is requesting a rolling walker with a seat, a personal reacher, a sleep spinal therapy system back brace, an instant calmer heating pad with travel power adapter, and a portable infrared heat therapy healing belt with battery. On December 3, 2014 Utilization Review non-certified the requested items noting the lack of documentation to support the medical necessity of their use. The MTUS and ODG were cited in the decisions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Rolling walker with seat:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG -walking aids

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee & leg chapter, walking aids

**Decision rationale:** This patient presents with continued complaints of pain and thoracic spasms. The current request is for ROLLING WALKER WITH SEAT. The ACOEM and MTUS Guidelines do not discuss wheeled walkers. The ODG Guideline provides a discussion regarding walking aids under its knee chapter. ODG states, 'Recommended for patients with conditions causing impaired ambulation when there is a potential for ambulation with these devices.' As documented in progress report dated 10/30/14, motor and sensory examination were within normal limits. X-ray and MRI of the thoracic spine and MRI of the lumbar spine were 'normal.' There are no documented issues with ambulation, limitations in home or community ambulation, nor is there any objective evaluation consistent with impaired ambulation or functional deficits. In this case, there is no description of impaired ambulation and examination finding do not document functional deficits that would require a walker. The requested walker IS NOT medically necessary.

**Personal reacher:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- Knee and leg chapter -DME

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee & Leg chapter under DME

**Decision rationale:** This patient presents with continued complaints of pain and thoracic spasms. The current request is for PERSONAL REACHER. The treating physician notes that 'providing him with a personal reacher would be helpful as it will enable him to extend his reach upward or downward without bending or stretching.' The ACOEM, MTUS and ODG guidelines do not discuss reachers. ODG guidelines, Knee & Leg chapter under DME, states that DME is defined as equipment which: 1. Can withstand repeated use, i.e., could normally be rented, and used by successive patients; 2. Is primarily and customarily used to serve a medical purpose; 3. Generally is not useful to a person in the absence of illness or injury; & 4. Is appropriate for use in a patient's home. CMS, 2005. DME is 'Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment DME below.' Durable medical equipments are provided to serve a medical purpose and there is no discussion regarding the medical necessity of this assistive device. There is no documentation of impairment or functional deficits that would require assistance with a reacher. This request IS NOT medically necessary.

**Sleep Spinal Therapy System back brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG lumbar supports

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation low back chapter, lumbar supports

**Decision rationale:** This patient presents with continued complaints of pain and thoracic spasms. The current request is for SLEEP SPINAL THERAPY SYSTEM BACK BRACE. 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 Guidelines under its low back chapter, lumbar supports states, 'Prevention: Not recommended for prevention. There is strong and 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 for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option).' In this case, the patient does not present with fracture, spondylolisthesis, or documented instability to warrant lumbar bracing. For nonspecific low back pain, there is very low-quality evidence. The requested back brace IS NOT medically necessary.

**Instant Calmer heating pad with travel power adapter:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- heat therapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter has the following regarding heat therapy

**Decision rationale:** This patient presents with continued complaints of pain and thoracic spasms. The current request is for INSTANT CALMER HEATING PAD WITH TRAVEL POWER ADAPTER. ODG-TWC.COM under the low back chapter has the following regarding heat therapy, 'Recommended as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain.' ODG further states, 'Active warming reduces acute low back pain during rescue transport. Combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control.' ODG guidelines allow for use of heat packs for acute pain, there is no indication for its use with chronic low back pain. In this case, the patient has chronic lower back pain and the current request is not supported by the ODG so this request IS NOT medically necessary.

**Portable Infrared heat therapy healing belt with portable battery (lithium ion):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- heat therapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter regarding infrared therapy

**Decision rationale:** This patient presents with continued complaints of pain and thoracic spasms. The current request is for PORTABLE INFRARED HEAT THERAPY HEALING BELT WITH PORTABLE BATTERY LITHIUM ION. The ACOEM and MTUS guidelines do not discuss Infrared therapy. Therefore, ODG guidelines were referenced. ODG under the low back chapter regarding infrared therapy states, 'Not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care, exercise.' In this case, the patient's low back pain is now well into the chronic phase. ODG states a limited trial may be considered for treatment of 'acute LBP.' In addition, this heat modality is not recommended over other heat therapies. This request IS NOT medically necessary.