

<b>Case Number:</b>	CM15-0017344		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	05/05/2010
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	01/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2015

### 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 37 year old female who sustained an industrial injury slip and fall on May 5, 2010. The injured worker underwent discectomy and lateral recess decompression at L5-S1 in June 2011 and discectomy with anterior retroperitoneal approach to the lumbar spine with partial corpectomy, resection of osteophytes, and anterior foraminotomy at the bilateral L5-S1 level on March 12, 2013. The injured worker was diagnosed with post laminectomy syndrome of the lumbar spine. According to the primary treating physician's progress report on December 23, 2014, the injured worker continues to experience right sided low back, leg and hip pain. An antalgic gait favoring the right side was noted. Current medications are listed as Xanax, Hydrocodone, Flexeril, Prozac, Motrin, Tylenol, Voltaren gel, and Cymbalta. Treatment modalities consist of right trochanteric bursa hip injection, topical and oral medication. The treating physician requested authorization for Mobileg Crutches and Contrast Compression Therapy device, 7 day rental. On January 8, 2015 the Utilization Review denied certification for Mobileg Crutches and Contrast Compression Therapy device, 7 day rental. Citation used in the decision process was the Official Disability Guidelines (ODG).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Mobileg Crutches:** 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), Treatment Index, 11th Edition (web), 2014, Hip & Pelvis, Walking Aids

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

**Decision rationale:** The patient presents with low back and right hip pain rated at 8-10/10. The request is for MOBILEG CRUTCHES. The request for authorization is not available. The patient is status-post L5/S1 microdisctomy 01/15/11 and L5/S1 anterior lumbar interbody fusion 03/12/13. Patient has decreased range of motion of the right hip. Patient had lidocaine injection to the hip and was pain free for 2-3 hours. The patient has been getting numbness in the right shin and foot which seems to come and go, but no change in strength. The patient's medications include Norco, Flexeril, Prozac, Xanax and Voltargen gel. Patient's work status is not available. ODG guidelines, knee chapter states the following about walking aids (canes, crutches, braces, orthoses, and walkers), "Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid." Treater has not provided reason for the request. Per progress report dated 11/19/14, treater has recommended right hip arthroscopy. However, in reviewing submitted documentation, treater does not discuss why the Mobileg crutches are needed by the patient. Furthermore, per progress report dated 12/02/14, treater states the patient's gait is normal. The patient is being scheduled for arthroscopic surgery of the hip joint but the treater does not explain why crutches would be required following an arthroscopic surgery. Therefore, the request IS NOT medically necessary.

**Contrast compression therapy device, 7 day rental:** 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), Treatment Index, 11th Edition (web), 2014, Hip & Pelvis, Venous Thrombosis, also see Knee Chapter

**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, continuous-flow cryotherapy

**Decision rationale:** The patient presents with low back and right hip pain rated at 8-10/10. The request is for CONTRAST COMPRESSION THERAPY DEVICE, 7 DAY RENTAL. The request for authorization is not available. The patient is status-post L5/S1 microdisctomy 01/15/11 and L5/S1 anterior lumbar interbody fusion 03/12/13. Patient has decreased range of motion of the right hip. Patient had lidocaine injection to the hip and was pain free for 2-3 hours. The patient has been getting numbness in the right shin and foot which seems to come and go, but no change in strength. The patient's medications include Norco, Flexeril, Prozac, Xanax and

Voltargen gel. Patient's work status is not available. ODG guidelines has the following regrading continuous-flow cryotherapy: "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling and narcotic useage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated." Treater has not provided reason for the request. Per progress report dated 11/19/14, treater has recommended right hip arthroscopy. However, there is no indication that the patient has undergone or is pending surgery. ODG guidelines does not support this type of device other than for postoperative recovery, and there is no indication that the patient has been authorized for surgery. Even for post-operative use, DVT prophylaxis would not be needed if there is no period of bed rest following the surgery. The hip surgery under discussion is arthroscopic surgery and the treater does not discuss post-operative needs. Therefore, the request IS NOT medically necessary.