

<b>Case Number:</b>	CM15-0040592		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	03/25/2014
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	02/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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: New York  
 Certification(s)/Specialty: Pediatrics, Internal 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 was a 56 year old female, who sustained an industrial injury, March 25, 2014. According to progress note of the injured workers chief complaint was lower back pain with radiation down the right leg. There was numbness, paresthesia and weakness noted. The injured worker described the pain as sharp, stabbing, burning, and constant. The injured worker was recently had blood in stool. The physical exam noted paralumbar spasms 2 plus tenderness with palpation on the right atrophy of the quadriceps. The range of motion of forward flexion the injured worker was able to reach the knees, lateral bending to the right 10 degrees, left 20-30 degrees with pain, extension 10 degrees, right and left resisted rotation were diminished. The straight leg was positive at 40 degrees on the right in the lateral thigh. The injured worker was diagnosed with low back pain, lumbar disc displacement and lumbar radiculopathy. The injured worker previously received the following treatments ultrasound of bilaterally carotid arteries, toxicology laboratory studies, chest x-ray, ice, heat application, non-steroidal anti-inflammatory medications, surgical consultation and lumbar steroid injection. The treatment plan included ice unit purchase, bone stimulator purchase, 3-1 commode purchase, front wheel walker purchase and TLSO L0464 purchase, on January 8 2015, there was a request for surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of Ice unit E0218: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** ODG guidelines do not comment on continuous-flow cryotherapy in the low back chapter. ODG states in many other chapters that continuous-flow cryotherapy is 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 usage. Upon review, the request dated February 10, 2015 for Reduction of Listhesis and Realignment of Junctional Kyphotic and Deformity and Posterior Lumbar Interbody Fusion with Instrumentation was denied. Without the anticipated surgery approved, the request is not medically necessary.

**Purchase of Bone stimulator E0748: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Per ODG guidelines, the use of bone growth stimulators is under study. There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at "high risk", but this has not been convincingly demonstrated. Upon review, the request dated February 10, 2015 for Reduction of Listhesis and Realignment of Junctional Kyphotic and Deformity and Posterior Lumbar Interbody Fusion with Instrumentation was denied. Without the anticipated surgery approved, the request is not medically necessary.

**Purchase of TLSO L0464: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 - Back Brace Post operative (fusion).

**Decision rationale:** Per ODG guidelines the use of back braces post operatively is under study. 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. Upon review, the request dated February 10, 2015 for Reduction of Listhesis and Realignment of Junctional Kyphotic and Deformity and Posterior Lumbar Interbody Fusion with Instrumentation was denied. Without the anticipated surgery approved, the request for the brace is not medically necessary.

**Purchase of 3 in 1 commode E0163:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** ODG guidelines do not comment on durable medical equipment in the low back chapter. ODG knee chapter states that 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. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. The request is not medically necessary and appropriate.

**Purchase of Front wheel walker E0143:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** ODG guidelines do not comment on durable medical equipment in the low back chapter. ODG knee chapter states that walking aids are recommended as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. ODG ankle chapter states that walking aids are recommended for patients with conditions causing impaired ambulation, when there is a potential for ambulation with these devices. Upon review, the request dated February 10, 2015 for Reduction of Listhesis and Realignment of Junctional Kyphotic and Deformity and Posterior Lumbar Interbody Fusion with Instrumentation was denied. Without the anticipated surgery approved, the request is not medically necessary.