
Notice of Independent Medical Review Determination

Dated: 10/18/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/18/2013
Date of Injury:	11/20/2010
IMR Application Received:	7/30/2013
MAXIMUS Case Number:	CM13-0005325

- 1) MAXIMUS Federal Services, Inc. has determined the request for purchase of LSO brace **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 30-day rental of Pneumatic Intermittent Compression Device **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for purchase of 3-in-1 commode **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for purchase of front wheel walker **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/30/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for purchase of LSO brace **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 30-day rental of Pneumatic Intermittent Compression Device **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for purchase of 3-in-1 commode **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for purchase of front wheel walker **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurological Surgery and is licensed to practice in California. 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 18, 2013:

"Clinical summary: According to the Supplemental Review of Medical Records dated 06/08/13 by Dr. [REDACTED], the patient had an Agreed Medical Evaluation (AME) internal medicine dated 03125/13 by Dr. [REDACTED], the patient complained of back pain. It was recommended that the patient was to be treated for the hypertension and review of medications. According to the AME orthopedic surgery dated 02120/13 by Dr. [REDACTED], stated that Dr. [REDACTED] had recommended surgery at L5-S1 and Dr. [REDACTED] agreed that the patient can have the surgery if desired and if the patient declined, then a supplemental report would be provided with factors and impairment. The patient was evaluated for psychological clearance for surgery by Dr. [REDACTED] and the patient was able to have the surgery. According to the [REDACTED] dated 11/13/12 by Dr. [REDACTED], the patient complained of low back pain that was in the belt line region and extended down to the left buttock, left thigh and on the back of the knee and occasionally extended down to the bottom of the foot. The patient had pain that was aching, sharp and with stiffness, spasms, burning sensation and occasional popping. Pain rate of 8-9/10 was noted. Physical examination

of the lumbar spine showed that there was antalgic gait pattern, favored the right lower extremity. There was palpable tenderness of the paravertebral muscles, bilaterally and centrally in the lower lumbar spine. The sensory was globally decreased over the left lower extremity. Range of motion in degrees: flexion 42, extension 12 and left and right lateral bend 20. The straight leg raise was positive on the left at 70 degrees. The patient's weight and height were not documented. The patient was diagnosed with L4-S1 stenosis, L4-S1 degenerative disc disease and left leg radiculopathy. A left L5-S1 transforaminal lumbar interbody fusion with cage and posterior spinal instrumentation and fusion was recommended. According to the nurse summary, the back surgery was scheduled on 7/18/2013. The plan was for front wheel walker E0143, urgent LSO brace L0510, urgent pneumatic intermittent compression device and urgent 3-in-1 commode E0163".

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (received 7/30/13)
- Utilization Review Determination (dated 7/18/13)
- Employee medical records from Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for purchase of LSO brace:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pg. 298-301 which is part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pp. 308, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on November 20, 2010. The medical records provided for review indicate the diagnoses of L4-S1 degenerative disc disease, left leg radiculopathy, and L4-S1 stenosis. Treatments have included diagnostic imaging studies, electrodiagnostic studies, possible lower back surgery, physical therapy, and medication management. The request is for purchase of a Lumbar Sacral Orthosis (LSO) Brace.

The MTUS/ACOEM, low back chapter, online version Lumbar support (corset) does not recommend a LSO brace for the treatment of low back disorders. A previous determination indicated that although there was pathology at the lumbar spine confirmed with electrodiagnostic studies, there was lack of documentation that the surgery had actually been performed and therefore there was lack of documentation of the medical necessity for the LSO brace. The provider indicated on 07/02/13 that the surgical procedure had been approved; however, there is lack of documentation that the requested procedure has been scheduled and/or actually performed. The medical records provided for review did not contain documentation regarding how this brace will be helpful in the overall

treatment plan. The requested for the purchase of an LSO brace **is not medically necessary and appropriate.**

2) Regarding the request for 30-day rental of Pneumatic Intermittent Compression Device:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (updated 06/07/13) Knee and Leg, Venous thromobosis, a medical treatment guideline, which is not part of the MTUS. The Expert Reviewer stated that the MTUS did not address the issue at dispute. The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG) (updated 06/07/13) Knee and Leg, Venous thromobosis and compression garments, which is not a part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on November 20, 2010. The medical records provided for review indicate the diagnoses of L4-S1 degenerative disc disease, left leg radiculopathy, and L4-S1 stenosis. Treatments have included diagnostic imaging studies, electrodiagnostic studies, possible lower back surgery, physical therapy, and medication management. The request is for 30-day Rental of Pneumatic Intermittent Compression Device.

The Official Disability Guidelines do not specifically recommend the pneumatic intermittent compression device, the use of standard compression garments serve the same purpose. The previous determination noted that there was a lack of documentation indicating the employee had lumbar surgery. A clinical note of 07/02/13, in the records provided for review, indicates the surgical procedure, lumbar fusion, had been approved, but there is lack of documentation to indicate that the procedure has been scheduled and/or performed. The clinical notes do not indicate a clear medical necessity for the requested compression device. The request for 30-day Rental of Pneumatic Intermittent Compression Device **is not medically necessary and appropriate.**

3) Regarding the request for purchase of 3-in-1 commode:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (updated 06/07/13) Knee and Leg, DME, a medical treatment guideline, which is not part of the MTUS. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on November 20, 2010. The medical records provided for review indicate the diagnoses of L4-S1 degenerative disc disease, left leg radiculopathy, and L4-S1 stenosis. Treatments have included diagnostic imaging studies, electrodiagnostic studies,

possible lower back surgery, physical therapy, and medication management. The request is for Purchase of 3-in-1 Commode.

The Official Disability Guidelines indicate the 3-in-1 Commode is generally recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME). A clinical note of 07/02/13, in the records provided for review, indicates the surgical procedure, lumbar fusion, had been approved, but there is lack of documentation to indicate that the procedure has been scheduled and/or performed. The records do not provide evidence of medical necessity for this device. Therefore, the request for Purchase of 3-in-1 Commode **is not medically necessary and appropriate**.

4) Regarding the request for purchase of front wheel walker:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (updated 6/7/13), Walking aids (canes, crutches, braces, orthoses, and walkers), a medical treatment guideline, which is not part of the MTUS. The Expert Reviewer found the MTUS does not specifically address the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on November 20, 2010. The medical records provided for review indicate the diagnoses of L4-S1 degenerative disc disease, left leg radiculopathy, and L4-S1 stenosis. Treatments have included diagnostic imaging studies, electrodiagnostic studies, possible lower back surgery, physical therapy, and medication management. The request is for Purchase of Front Wheel Walker.

The Official Disability Guidelines indicate that disability, pain and age-related impairments seem to determine the need for a walking aid. The clinical note of 07/02/13 states that the surgery has been approved, but the records do not document this patient has had surgery and did not indicate that he has difficulty with walking. In this case, the medical records provided for review lack evidence of surgical intervention or significant mobility issues. Therefore, the request for Purchase of Front Wheel Walker **is not medically necessary and appropriate**.

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/hs

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.