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| Case Number: | CM14-0106166 | | |
| Date Assigned: | 07/30/2014 | Date of Injury: | 07/24/2007 |
| Decision Date: | 10/03/2014 | UR Denial Date: | 06/30/2014 |
| Priority: | Standard | Application Received: | 07/09/2014 |

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 49 year-old female who reported an injury on 07/24/2007 when she pulled and twisted at the same time while transferring a bale of hay. The diagnoses included chronic low back pain and lumbar disc degeneration. Past treatments included epidural steroidal injections, physical therapy, and TENs unit therapy. Diagnostic studies included MRIs of the lumbar spine on 02/14/2011, and on 12/03/2013. It was noted on 06/17/2014 that the injured worker reported low back pain radiating into the right lower extremity. The physical examination findings included no apparent distress, a slow gait with the use of a cane, the gait was not antalgic, and no foot drop was noted. Additionally, there were no lumbar muscular spasms, a negative straight leg raise test, and deep tendon reflexes were 2/4. Medications included tramadol and robaxin. The treatment plan was for medications, future epidural steroid injections, and a walker with a seat. The rationale for the walker and the request for authorization form were not provided for the review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Walker with Seat: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation-Knee & Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Insert Section (for example Knee)>, <Insert Topic (for example Total Knee Arthroplasty)>

Decision rationale: The request for a walker with a seat is not medically necessary. The Official Disability Guidelines state that assistive devices for ambulation can reduce pain associated with osteoarthritis. Frames or wheeled walkers are preferable for patients with bilateral disease. The injured worker has a history of low back pain radiating into the right lower extremity. The injured worker has been treated with epidural steroidal injections, physical therapy, and TENS unit therapy. The guidelines recommend wheeled walkers only for patients with bilateral knee osteoarthritis. The injured worker does not have this condition and there was no documentation of significant motor deficits in the bilateral lower extremities. As such, the request is not medically necessary.