

Case Number:	CM14-0014450		
Date Assigned:	02/28/2014	Date of Injury:	12/11/2010
Decision Date:	07/14/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/05/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Ohio and Texas. 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 12/11/2010, the mechanism of injury was not provided. The injured workers diagnoses included cervical spine strain, thoracic spine strain, left shoulder internal derangement, lumbar spine disc rupture, left cubital tunnel syndrome, and status post left elbow ulnar nerve decompression. The clinical note dated 12/11/2013 noted the injured worker presented with pain in the neck, upper back, lower back, left elbow and head. Upon examination, the injured worker had intact sensation to light touch to the left lateral shoulder, left index tip, and left dorsal thumb web. It was also noted that the injured worker had diminished sensation to light touch to the left small tip. The treatment plan included shockwave therapy, aqua therapy, acupuncture, portable interferential unit, and a seat cushion for coccyx support. The provider's rationale for the requests was not provided. The Request for Authorization form was submitted on 12/11/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

SEAT CUSHION (COCCYX SUPPORT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation drugs.com.coccyn.injuryaftercare-instructions.

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

Decision rationale: The request for Seat Cushion (Coccyx Support) is not medically necessary. The Official Disability guidelines state that durable medical equipment may be recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) which includes that the device can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. The guidelines also state that most durable medical equipment is primarily used for convenience. As there is lack of rationale provided as to way the injured worker needs this requested device and there is lack of objective examination findings that would benefit from this device this request cannot be support. As such, this request is not medically necessary.