

<b>Case Number:</b>	CM14-0015914		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	08/01/2007
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/07/2014

### 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 & Rehabilitation and is licensed to practice in California and Washington. 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 37-year-old female who reported an injury on 08/01/2007. The injury occurred when the injured worker slipped and fell. On 01/20/2014, the injured worker presented with complaints of neck pain, low back pain, insomnia, depression/anxiety, sexual dysfunction, and GERD. Upon examination of the cervical spine, there was diffuse nonspecific tenderness, and positive axial head compression. Inspection of the lumbar spine revealed left paralumbar tenderness, and a positive straight leg raise, bowstring sign, Lasgue's sign, and sciatic notch tenderness. The provider recommended an ergonomic chair. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ERGONOMIC CHAIR:** 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, Ergonomic interventions.

**Decision rationale:** The Official Disability Guidelines recommend ergonomic interventions as an option for a return to work program for injured workers, but there is conflicting evidence for prevention, so case by case recommendations are necessary. There are no good quality evidence of the effectiveness or ergonomic or modification of risk factors in prevention of lower back pain. A systematic review of preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective, and other interventions not effective including stress management, shoe inserts, back supports, ergonomic back education, and reduced lifting programs. In this case, the included medical documentation lacked evidence of a specific medical need for an ergonomic chair. The provider's rationale was not provided in the request. As such, the request for Ergonomic chair is not medically necessary and appropriate.