

Case Number:	CM14-0122258		
Date Assigned:	09/16/2014	Date of Injury:	04/19/1994
Decision Date:	10/21/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	08/01/2014

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. 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 60-year-old male who reported an injury on 04/19/1994. The mechanism of injury was the injured worker was crushed between 2 forklifts. Prior treatments included a TENS unit, epidural injections, and occipital nerve blocks as well as trigger point injections. The injured worker's medication included Lidoderm patches, Elavil, and naproxen. The injured worker had an MRI of the cervical spine. The prior surgical history included an ulnar surgery. The injured worker had back surgery. The request was made for hardware removal. The documentation of 06/10/2014 revealed the injured worker was scheduled for removal of hardware from the lumbosacral spine and the surgical intervention was noted to have been cancelled. The examination of the lumbar spine revealed the injured worker had moderate to moderately severe pain of the lumbosacral spine which occasionally became severe. The injured worker had recurrent radiation of pain to the lower extremities. The physical examination revealed the injured worker had moderate paraspinal muscle guarding with tenderness right greater than left. The injured worker had decreased range of motion of the cervical spine. There was slight hypesthesia of the anterior right thigh. There was slight weakness of the right great toe extensor and the right anterior tibialis and no quadriceps weakness. The deep tendon reflexes were absent in the bilateral ankles. The sciatic stretch sign was slightly positive on the right. The diagnoses included status post lumbar laminectomy with lumbar fusion and interbody cages L4-5 bilaterally; degenerative disc disease L5-S1 with associated facet arthropathy resulting in bilateral neural foraminal narrowing greater on the right than left. The treatment plan included removal of the retained metal from the lumbosacral spine from L4 through the sacrum. There was no request for authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable Medical Equipment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section for cold packs

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee & Leg Chapter, Durable Medical Equipment (DME)

Decision rationale: The documentation submitted for review was of poor fax quality and difficult to read. There was no specific durable medical equipment requested. As such, the requested specific guidelines could not be applied. As such, general guidelines would apply. The Official Disability Guidelines indicate that durable medical equipment is recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment including can withstand repeated use as it could normally be rented and used by successive patients, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. The clinical documentation submitted for review failed to provide a legible copy to indicate the type of durable medical equipment being requested. Additionally, the request as submitted failed to indicate whether the request was for rental or purchase of durable medical equipment. Given the above, the request for durable medical equipment is not medically necessary.