

Case Number:	CM14-0170260		
Date Assigned:	10/20/2014	Date of Injury:	10/20/2012
Decision Date:	11/26/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	10/15/2014

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 Occupational Medicine 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:

Patient is a 51 year-old female with date of injury 10/20/2010. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/10/2014, lists subjective complaints as pain in the lower back and right thigh. Patient had a right bursa injection in 10/2014 which was noted to help only a little, and for one day. Objective findings: Examination of the lumbar spine revealed tenderness of the paravertebral muscles, especially on the right. Range of motion is restricted in flexion and extension. Tenderness was also noted over the right sacroiliac joint, right greater trochanter and distal gluteus. Gaenslen's test was positive on the right. Sensation was normal to light touch for the bilateral lower extremities. Motor strength was within normal limits. Straight leg raising test was negative bilaterally. Diagnosis: 1. Sacroiliitis 2. Sacroiliac ligament strain/sprain 3. Lumbar myofascial sprain/strain 4. Osteoarthritis, right hip 5. Right hip bursitis. The sacroiliac joint fusion with which the requested DME is associated was determined to be not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

A front wheeled walker and an SI joint belt for post-operative use: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): table 2.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): table 2.

Decision rationale: The above requested was intended for postoperative use. The sacroiliac joint fusion procedure, with which the requested DME is associated, was determined to be not medically necessary. Therefore, the request for a front wheeled walker and an SI joint belt for post-operative use is not medically necessary and appropriate.