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| Case Number: | CM14-0172122 | | |
| Date Assigned: | 10/23/2014 | Date of Injury: | 04/20/2010 |
| Decision Date: | 12/17/2014 | UR Denial Date: | 10/06/2014 |
| Priority: | Standard | Application Received: | 10/17/2014 |

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 Internal Medicine and is licensed to practice in New Jersey and New York. 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 52-year-old female who reported an injury on 04/24/2010. The mechanism of injury was a fall. Her diagnoses include lumbar discopathy, chronic right S1 radiculopathy, status post right total knee arthroplasty, and rule out right hip internal derangement. Her past treatments include physical therapy, right knee Synvisc injections, lumbar spine steroid injections, bracing, and home health occupational therapy. The diagnostic studies include an MRI of the lumbar spine on 09/22/2013, which revealed mild disc herniations at L1-2 and L2-3 with mild central canal stenosis and mild bilateral foraminal narrowing at L5-S1 secondary to degenerative facet changes. Her past surgical history includes right knee arthroscopic surgery in 10/2012 and right knee total arthroplasty on 09/07/2013. On 08/27/2014, the injured worker rated her low back a 9/10 and increased pain with activity. She also reported right knee pain that was aggravated with activity and rated this pain 5/10. The physical exam of the lumbar spine revealed tenderness to palpation of the paraspinals, decreased range of motion, decreased motor strength, and decreased reflexes. The physical exam findings of the right knee revealed tenderness to palpation of the lateral joint line, decreased range of motion, and minimal residual swelling. Additionally, there was no evidence of lumbar spine or right knee instability during the exam. Her current medications were noted to include tramadol, Cidaflex, ketoprofen, Norco, Methoderm gel, and Terocin patches. The treatment plan was noted to include a recommendation for lumbar spine fusion. A request was received for a TLSO and a front wheel walker. A rationale was not provided. A Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

TLSO: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The request for a TLSO is not medically necessary. The California MTUS/ACOEM Guidelines do not recommend lumbar supports, as they have not shown any lasting benefit beyond the acute phase of symptom relief. The injury occurred in 04/2010, which is well beyond the acute phase. Therefore, the request is not supported by the evidence based guidelines. As such, the request for a TLSO is not medically necessary.

Front wheel walker: 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) Knee & Leg, Walking aids.

Decision rationale: The request for a front wheel walker is not medically necessary. The Official Disability Guidelines recommend walking aids for chronic pain associated with knee conditions, especially for maximal limb offloading for overweight individuals. There was no evidence of right knee instability during the clinical visit on 08/27/2014. Additionally, there was insufficient documentation indicating the injured worker to be overweight. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the request for a front wheel walker is not medically necessary.