

Case Number:	CM14-0022483		
Date Assigned:	05/09/2014	Date of Injury:	04/06/2011
Decision Date:	07/18/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	02/21/2014

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 Orthopedic Surgery 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 56 year old female who reported an injury on 04/06/2011 due to a fall. The injured worker had complaints of intermittent neck pain, rated 3/10, with stiffness. She also had complaints of frequent low back pain rated 8/10, with radiation to the left lower extremity, right shoulder pain rated 2-3/10 and left shoulder pain rated 3/10. She also reports bilateral wrist pain. The physical examination on 01/10/2014 revealed lumbar spine paraspinal spasms. Straight leg raise was positive bilaterally, motor strength revealed weakness in the extensor hallucis longus, tibialis anterior, and peroneus longus at 4/5 and there was a decreased sensation to light touch over the L5 dermatome on the dorsum of the feet. Diagnostic studies were not submitted for review. Physical therapy reports were submitted. The injured worker had physical therapy twice a week for six weeks and stated it was very effective. The medications were Flurbiprofen gel, Ketoprofen gel, Norco, Soma and Naprosyn. The injured worker had an anterior cervical decompression and fusion on 08/01/2013. The diagnoses were status post anterior cervical decompression and fusion at C6-C7, L4-L5 herniated nucleus pulposus with instability at L4-L5, rule out L5 pars fracture with bilateral lower extremity radiculopathy. The treatment plan was for the injured worker to undergo anterior posterior fusion and decompression at L4-L5 and to accommodate her with a commode and front wheeled walker to help with recovery. The rationale was submitted. The request for authorization 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:

FRONT WHEELED WALKER: 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), Knee and Leg Chapter- Walking Aids, Durable Medical Equipment.

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

Decision rationale: The request for front wheeled walker is not medically necessary.. The document submitted for review is lacking diagnostic studies. Official Disability Guidelines state a walker is recommended as indicated for knee pain or osteoarthritis of the knees. The injured worker does not have a diagnosis of knee pain or other impairments. The injured worker stated she did well with physical therapy and there was no noted problem of walking or being unbalanced. The guidelines do not recommend a walker for back surgery. Therefore, the request is not medically necessary.

3:1 COMMUNE: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter- Walking Aids, Durable Medical Equipment.

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.

Decision rationale: The request for one commode is medically necessary. Official Disability Guidelines states that DME(Durable Medical Equipment) is recommended generally if there is a medical need. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury., but environmental modifications are considered not primarily medical in nature. Certain durable medical equipment are medically necessary if the patient is bed or room confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for the injury, infection, or conditions that result in physical limitations. The injured worker is scheduling surgery. Therefore, the request is medically necessary.