

Case Number:	CM14-0027271		
Date Assigned:	06/13/2014	Date of Injury:	11/16/2003
Decision Date:	07/16/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	03/04/2014

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 and Rehabilitation, Pain Medicine and is licensed to practice in Texas. 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 73 year old female whose date of injury is 11/06/2003. The mechanism of injury is not described. Lumbar MRI dated 11/07/13 revealed diffuse spondylosis without evidence of spondylolisthesis, endplate sclerotic changes, disc desiccation and mild levoscoliosis. Progress report dated 01/09/14 indicates the injured worker complains of low back pain with radiation to the lower extremities, neck pain with radiation to the shoulders, mild left lower extremity weakness and numbness status post left total knee replacement, bilateral knee pain improved after surgery, depression, coccyx area pain, and difficulty sleeping. Diagnoses are lumbar strain, cervical strain status post C4-7 fusion on 12/07/09, left knee pain status post surgery 02/04 and total knee replacement in 09/06, posterior tibial nerve injury, post traumatic headaches, secondary depression, coccygeal strain, insomnia and left shoulder pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

WHEELED WALKER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee and Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: Based on the clinical information provided, the request for wheeled walker is not recommended as medically necessary. The submitted records fail to provide a current, detailed physical examination. There is no clear rationale provided to support a wheeled walker at this time, and no indication that the injured worker requires assistance with ambulation as required by the Official Disability Guidelines. The request is not medically necessary.

PURCHASE RS4I INTERFERENTIAL MUSCLE STIMULATOR UNIT AND CONDUCTIVE GARMENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 118-120.

Decision rationale: Based on the clinical information provided, the request for purchase RS4i interferential muscle stimulator unit and conductive garment is not recommended as medically necessary. The submitted records indicate that the injured worker underwent a trial of the stimulator; however, there are no objective measures of improvement provided to establish efficacy of treatment and support purchase of the unit in accordance with CA MTUS guidelines. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals are provided. The request is not medically necessary.

LUMBAR BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

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 Chapter, Lumbar supports.

Decision rationale: Based on the clinical information provided, the request for lumbar brace is not recommended as medically necessary. There is no documentation of instability, compression fracture or spondylolisthesis. There is no clear rationale provided to support lumbar brace at this time. The Official Disability Guidelines note that lumbar braces are not recommended for the prevention of low back pain. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. The request is not medically necessary.

BEDRAIL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee and Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin, Hospital Beds and Accessories.

Decision rationale: Based on the clinical information provided, the request for bedrail is not recommended as medically necessary. There is no clear rationale provided to support the request. There is no current, detailed physical examination submitted for review. There is no documentation of seizures, vertigo, disorientation, and neurological disorders to support bedrails. The request is not medically necessary.