

Case Number:	CM14-0047310		
Date Assigned:	07/02/2014	Date of Injury:	03/02/2003
Decision Date:	08/26/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/15/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 67-year-old female who reported an injury on 03/02/2003 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her low back, bilateral lower extremities, and bilateral hands. The injured worker's treatment history included anti-inflammatory medications, bracing, customized foot orthotics, physical therapy, and aquatic therapy. The injured worker was evaluated on 03/11/2014. It was noted that the injured worker had continued pain complaints of the bilateral feet. Physical findings included tenderness to palpation of the paraspinous musculature of the lumbar spine with tenderness to palpation of the sacroiliac joint and a positive sacroiliac stress test, Fabere's test, and Gaenslen's test. It was noted that the injured worker had a negative straight leg raising test and a positive Kemp's test with decreased range of motion. The injured worker's diagnoses included plantar fasciitis with right calcaneal spur, right sacroiliac joint sprain/strain, and lumbar sprain/strain. The injured worker's treatment plan included continuation of medications, blood work, and continuation of aquatic therapy. A request was made for medications, a conductive garment for an interferential unit, a replacement lumbosacral brace, and a left wrist replacement brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Conductive garment for Interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

Decision rationale: The requested conductive garment for interferential unit is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend a conductive garment to provide coverage to large areas when using an interferential or TENS unit. However, the clinical documentation submitted for review does not provide any evidence of objective functional improvement related to the use of an interferential unit. There is no documentation that the injured worker is using an interferential unit or has undergone any use of an interferential unit for the lumbar spine. As such, the requested conductive garment for the interferential unit is not medically necessary or appropriate.

Replacement Lumbar Spine brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation ACOEM guidelines, updated low back chapter (2008); Official Disability Guidelines (ODG)-TWC, Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: The requested replacement lumbar spine brace is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of lumbar spine bracing for acute or chronic spine injuries. Although it is noted that the injured worker has previously used a lumbar brace, there were no exception factors to support extending treatment beyond guideline recommendations provided. Therefore, a replacement lumbar spine brace is not medically necessary or appropriate.

Shower Chair: 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)-TWC, Knee and Leg Procedure Summary.

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, Durable Medical Equipment (DME).

Decision rationale: The requested decision for a shower chair is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address durable medical equipment. Official Disability Guidelines do not recommend the use of durable medical equipment such as shower chairs as medically necessary unless the injured worker is restricted to

a single room and is not able to participate in the activities of daily living that the equipment is being requested for. As such, the requested shower chair is not medically necessary or appropriate.