MAXIMUS Federal Services

Case Number:	CM14-0055518		
Date Assigned:	07/09/2014	Date of Injury:	02/21/2009
Decision Date:	09/05/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/24/2014

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, has a subspecialty in Pain Medicine, and is licensed to practice in New York and 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 41 year old female who had a work related injury on 2/21/09. No documentation of the mechanism of injury was provided for review. She hurt her back and her shoulder. She underwent an L5-S1 microdiscectomy on 11/7/13, and left shoulder arthroscopic subacromial decompression on 6/20/13. An MRI of the left shoulder dated 5/6/13 showed supraspinatus and infraspinatus tendinosis. There was glenohumeral joint effusion. No other significant findings are noted. An MRI of the lumbar spine dated 5/6/13 showed a right paracentral disc protrusion at L5-S1 that abuts the thecal sac and produces spinal canal narrowing. There was right lateral recess and right neuroforaminal narrowing, as well as right posterolateral annular tear/fissure. No other significant findings are noted. The most recent clinical record submitted for review is dated August 2014; the injured worker was seen in follow-up. The injured worker underwent physical therapy. There is tenderness to palpation over the paraspinal musculature. There is normal lordosis. Flexion is 60 degrees and extension is 25 degrees. Right and left lateral bending is 25 degrees. Strength is rated 5/5 in the lower extremities. There is diminished sensation over the bilateral S1 dermatomes. There are 2+ reflexes in the patella and Achilles. There are negative Achilles clonus and negative straight leg raises. A lumbar MRI dated 3/16/14 showed recurrent disc herniation at L5 to S1. The diagnosis was recurrent disc herniation. The recommendation was for a fusion because more than 50% of the facets will have to be removed in order to perform a revision decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chairback - Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

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: Lumbar supports are not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. They are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low blood pressure (very low-quality evidence, but may be a conservative option). They are under study for post-operative use. Among home care workers with previous low back pain, adding patient-directed use of lumbar supports to a short course on healthy working methods may reduce the number of days when low back pain occurs, but not overall work absenteeism. As such, medical necessity has not been established.

3-1 Commode Chair - Purchase: 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 chapter, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: There is no clinical evidence submitted that would prevent the injured worker from using a bathroom commode. Therefore medical necessity has not been established.

Motorized Cold Therapy Unit - Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Continuous-flow cryotherapy.

Decision rationale: Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated.

Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. The injured worker's surgery was in 2013. Therefore medical necessity has not been established.

Ulta Sling - Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Postoperative abduction pillow sling.

Decision rationale: Slings are recommended as an option following surgery; however, the injured worker had a left shoulder arthroscopic subacromial decompression on 6/20/13. There is no clinical evidence that the injured worker requires a sling. Therefore medical necessity has not been established.