

Case Number:	CM15-0140145		
Date Assigned:	07/29/2015	Date of Injury:	07/06/2010
Decision Date:	08/27/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, Florida, California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 59 year old female who sustained an industrial injury on 7-6-2010. She reported injury to her right wrist and hand due to a poor ergonomic workstation. Other areas of concern were the neck, right shoulder, right thumb, and lower back and has been diagnosed with cervical and lumbar degenerative disc disease with upper and lower extremity radicular symptoms, right shoulder strain, and right hand tendinitis and mild CMC joint arthritis. Treatment has consisted of medications, modified work duty, and physical therapy. There was tenderness of the cervical spine and paraspinal musculature. There was spasm. There was a positive Spurling's sign bilaterally. There was tenderness of both shoulders with positive impingement sign. There was tenderness of the lumbar spine and pain with range of motion. There was positive straight leg raise bilaterally. The treatment plan included spine surgery, 20 hours of in home services, walker, and a lumbar brace. The treatment request included a lumbar brace, walker, and 20 hours per week of in house services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar brace: 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), Low Back, Pain, Knee.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): ACOEM, Chapter 12, Low back, page 298.

Decision rationale: This claimant was injured about five years ago, with alleged injury to her right wrist and hand due to a poor ergonomic workstation. Other diagnoses were cervical and lumbar degenerative disc disease with upper and lower extremity radicular symptoms, right shoulder strain, right hand tendinitis and mild CMC joint arthritis. Treatment has consisted of medication, modified work duty, and physical therapy. There was tenderness of the lumbar spine and pain with range of motion. There was positive straight leg raise bilaterally. A surgery was planned; it is not clear if it was certified. The California MTUS, specifically Chapter 12 of ACOEM dealing with the low back, note on page 298: Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In this case, the claimant is well past the acute phase of care. There is no evidence of lumbar spinal instability, or spondylolisthesis. Therefore, this request is not medically necessary.

Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, Pain, Knee.

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 Foot sections, under Walking Aids.

Decision rationale: As shared previously, this claimant was injured about five years ago, with alleged injury to her right wrist and hand due to a poor ergonomic workstation. Other diagnoses were cervical and lumbar degenerative disc disease with upper and lower extremity radicular symptoms, right shoulder strain, right hand tendinitis and mild CMC joint arthritis. Treatment has consisted of medication, modified work duty, and physical therapy. There was tenderness of the lumbar spine and pain with range of motion. There was positive straight leg raise bilaterally. A surgery was planned; it is not clear if it was certified. The MTUS is silent. Regarding walking aids, the ODG notes in the Knee and Ankle sections: Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003). In this case, the status of disability, pain and age-related impairment is not fully expounded on to support the request. The request is not medically necessary. In this case, I do not supported adding mobility aids in cases where people can walk unaided, as they can weaken the musculature post surgery, can the claimant can become reliant on them rather than working their home program to fully rehabilitate. I would support a non-certification.

20 hours per week of in house services: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, Pain, Knee.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51 of 127.

Decision rationale: As noted previously, this claimant was injured about five years ago, with alleged injury to her right wrist and hand due to a poor ergonomic workstation. Other diagnoses were cervical and lumbar degenerative disc disease with upper and lower extremity radicular symptoms, right shoulder strain, right hand tendinitis and mild CMC joint arthritis. Treatment has consisted of medication, modified work duty, and physical therapy. There was tenderness of the lumbar spine and pain with range of motion. There was positive straight leg raise bilaterally. A surgery was planned; it is not clear if it was certified. Regarding home health care services, the evidence-based guides note that is recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. This claimant appears to need it for non-medical services and activities of daily living. However, the guide specifically notes that medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004) As presented in the records, the evidence-based MTUS criteria for home health services evaluation would not be supported and is not medically necessary.