

<b>Case Number:</b>	CM14-0123260		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	11/27/2009
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	07/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2014

### 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 and 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 53-year-old female who reported an injury on 11/27/2009. Mechanism of injury was not provided. The injured worker had a diagnosis of spondylolisthesis. Past treatments included physical therapy, medications, chiropractic therapy, acupuncture therapy and epidural injections. Diagnostic testing included an MRI of the lumbar spine without contrast on 05/29/2014 and x-rays of lumbar spine. The injured worker underwent anterior cervical decompression and fusion at C5-6 and C6-7. The injured worker complained of back tenderness, increased pain on range of motion on 07/01/2014. The physical examination revealed an antalgic gait, back tenderness, increased pain on range of motion. Straight leg raise was positive in the right lower extremity. Medications were not provided. The treatment plan was for a front wheel walker. The rationale for the request was not submitted. The Request for Authorization form was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Front Wheel 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), Treatment in Workers Comp 18th edition, 2013 Update, Knee and Leg chapter - DME

**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 (canes, crutches, braces, orthoses, & walkers).

**Decision rationale:** The request for Front Wheel Walker is not medically necessary. The injured worker complained of increased pain with range of motion. The Official Disability Guidelines (ODG) state disability, pain, and age-related impairments seem to determine the need for a walking aid. The guidelines note assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. The documents reviewed indicate the injured worker experiences lower back pain, however there is no evidence to support a diagnosis of osteoarthritis. The requesting physician's rationale for the request is not indicated within the provided documentation. Therefore the request for front wheel walker is not medically necessary.