

Case Number:	CM14-0161285		
Date Assigned:	10/06/2014	Date of Injury:	12/09/2003
Decision Date:	11/06/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	10/01/2014

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 Management and is licensed to practice in California. 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:

This is a male patient with the date of injury of December 9, 2003. A Utilization Review was performed on September 12, 2014 and recommended non-certification of 1 assistive cane between 9/10/2014 and 1 lumbar back support between 9/10/2014 and 10/25/2014. An Orthopedic Reevaluation dated August 27, 2014 identifies Subjective Complaints of lower back pain with radiation into the bilateral legs causing him trouble with lifting his legs and walking. He reports that he has increased pain in the bilateral hips with weakness in the bilateral legs. Objective Findings identify tenderness to palpation at the levels of L5-S1 bilaterally as well as the paravertebral musculature. There is a positive straight leg raising test on the left. There is restricted range of motion due to complaints of discomfort and pain. There are muscle spasm noted. There is decreased quadriceps strength. Current Diagnoses identify lumbar strain with radiculopathy, history of posterior decompression, right knee sprain/strain, status post right knee arthroscopy in April 2007, right knee patellofemoral chondromalacia and patellofemoral subluxation, left knee sprain/strain with patellofemoral chondromalacia and subluxation. Treatment Plan identifies lumbar back support to help with daily activities and cane to help with ambulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) Assistant Cane between 9/10/2014 and 10/25/2014: 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), 11th edition (web) 2014, Low back, Walking Aids

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

Decision rationale: Regarding the request for One (1) Assistant Cane between 9/10/2014 and 10/25/2014, Official Disability Guidelines state that assistive devices are recommended to assist with ambulation for patients with arthritis. Within the documentation available for review, the requesting physician has not identified why the patient would benefit from a cane. In the absence of such documentation, the currently requested One (1) Assistant Cane between 9/10/2014 and 10/25/2014 is not medically necessary.

One (1) Lumbar Back Support between 9/10/2014 and 10/25/2014: 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), 11th edition (web) 2014, Low back, Walking Aids

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Low Back Chapter, Lumbar Supports

Decision rationale: Regarding the request for One (1) Lumbar Back Support between 9/10/2014 and 10/25/2014, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of his treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested One (1) Lumbar Back Support between 9/10/2014 and 10/25/2014 is not medically necessary.