

<b>Case Number:</b>	CM15-0012034		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	03/05/2012
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	12/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 45 year old male, who sustained an industrial injury on 3/5/12. He has reported thoracic back pain related to a fall. The diagnoses have included contusion right thoracic spine, degenerative spondylosis and chronic pain. Treatment to date has included physical therapy, heat therapy, radiofrequency neurotomy and oral medications. As of the PR2 dated 12/9/14, the injured worker reported mid/low back pain and indicated partial pain relief from current medications. The treating physician requested a seat cushion for lumbar spine to use at work. On 12/25/14 Utilization Review non-certified a request for a seat cushion for lumbar spine. The utilization review physician cited the ODG guidelines. On 1/21/15, the injured worker submitted an application for IMR for review of a seat cushion for lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Seat cushion, quantity: 1:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Knee and Leg Chapter, Durable Medical Equipment

**Decision rationale:** Based on the 12/09/14 progress report provided by treating physician, the patient presents with chronic mid/ low back pain due to degenerative spondylosis of the thoracic/ lumbar spine. The request is for SEAT CUSHION QUANTITY 1. The patient is status post radiofrequency neurotomy on 02/25/14. Patient's diagnosis per Request for Authorization form dated 12/17/14 included back pain. Patient's medications include Flexeril, Voltaren Gel, Lidoderm patches, Ibuprofen, Norco and Simvastatin. The patient is working full duty. The MTUS and ACOEM Guidelines do not address this request. ODG-TWC, Knee and Leg Chapter, under Durable Medical Equipment states: "Recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME). DME is an equipment that can withstand repeated use; primarily and customarily used to serve a medical purpose; generally not useful to a person in the absence of illness or injury; is appropriate for use in the patient's home." ACOEM page 262 regarding ergonomics states, "The clinician may recommend work and activity modifications or ergonomic redesign of the workplace to facilitate recovery and prevent recurrence. The employer's role in accommodating activity limitations and preventing further problems through ergonomic changes is key to hastening the employee's return to full activity." Treater is requesting "seat cushion for [REDACTED] driver," per treater report dated 12/09/14. The treater has not provided reason for the request, nor discussed the exact use of this equipment. Furthermore, Labor Code 4610.5(2) definition of medical necessity. "Medically necessary" and "medical necessity" meaning medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury. However, ACOEM does allow for ergonomic modification and this patient is returning to work as a driver. A seat cushion is ergonomic modification to potentially prevent re-injury. The request IS medically necessary.