MAXIMUS Federal Services

Case Number:	CM15-0095898		
Date Assigned:	05/28/2015	Date of Injury:	07/26/2002
Decision Date:	07/03/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/18/2015

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: Florida
Certification(s)/Specialty: Neurology, Pain Management

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 55 year old male, who sustained an industrial injury on July 26, 2002. He reported low back pain with radiating pain to the right lower extremity. The injured worker was diagnosed as having lumbar degeneration, sacrum disorders, strain/sprain of the lumbar spine and recurrent depression. Treatment to date has included radiographic imaging, diagnostic studies, right ankle surgery, right trigger finger release, lumbar spine surgical intervention times two, steroid injections, conservative care, medications and work restrictions. Currently, the injured worker complains of low back pain with right lower extremity pain. The injured worker reported an industrial injury in 2002, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on June 9, 2015, revealed continued pain as noted. He reported improvement with previous injections. He reported having information regarding the benefits of ergonomic seating and discussed the option with the physician. Two ergonomic chairs and massage therapy were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage Therapy x 4 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines massage therapy Page(s): 174.

Decision rationale: The medical records report previous treatment without resolution of pain but does not detail previous physical therapy sessions. MTUS supports PT (massage therapy) for patients with identified deficits with goals for continued therapy. As the medical records do not indicate physical exam findings with demonstrated goals for further therapy, additional PT or massage therapy is not supported as medical necessary.

Retrospective: Ergonomic 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 - low back, orthotic device.

Decision rationale: The injured worker was diagnosed as having lumbar degeneration, sacrum disorders, strain/sprain of the lumbar spine and recurrent depression. Treatment to date has included radiographic imaging, diagnostic studies, right ankle surgery, right trigger finger release, lumbar spine surgical intervention times two, steroid injections, conservative care, medications and work restrictions The medical records provided for review do not indicate any objective findings in support of spine instability, compression fracture, or spondylolithesis. Without demonstrated findings of instability, ergonomic chair is not supported under ODG guidelines. Therefore, the requested treatment is not medically necessary.

Purchase of an Additional Chair: 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 - low back, orthosis device.

Decision rationale: The injured worker was diagnosed as having lumbar degeneration, sacrum disorders, strain/sprain of the lumbar spine and recurrent depression. Treatment to date has included radiographic imaging, diagnostic studies, right ankle surgery, right trigger finger release, lumbar spine surgical intervention times two, steroid injections, conservative care, medications and work restrictions The medical records provided for review do not indicate any objective findings in support of spine instability, compression fracture, or spondylolithesis. Without demonstrated findings of instability, ergonomic chair is not supported under ODG guidelines. Therefore, the requested treatment is not medically necessary.