

Case Number:	CM13-0043352		
Date Assigned:	12/27/2013	Date of Injury:	05/16/2002
Decision Date:	04/24/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/23/2013

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, and is licensed to practice in Illinois. 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 patient is a 72-year-old male who reported an injury on 5/16/02. The patient has had a history of low back pain for years after his injury at work; the patient was injured while operating a jack hammer. The patient is status post L3-S1 posterior lumbar interbody fusion and an L2-3 radical discectomy and interbody fusion of the L2-3. The patient was seen on 9/13/13 for complaints of low back pain rated at 9/10, also described as achy, dull pain that radiates into his bilateral lower extremities. Objective findings include weakness and numbness in the bilateral lower extremities, as well as decreased deep tendon reflexes in the bilateral knees and ankles. The patient was seen on 11/8/13 with continued low back pain rated at 8/10, described it as achy and dull with weakness in both legs.

IMR ISSUES, DECISIONS AND RATIONALES

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

SPINAL CORD STIMULATION TRIAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101,105-107. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107.

Decision rationale: According to the California MTUS guidelines, prior to a patient undergoing either a pre-intrathecal drug delivery system or spinal cord stimulator trial, they must undergo a psychological evaluation. This patient has not undergone a psychological evaluation at this time. Without having a psychological clearance indicating that the patient is realistic in his expectations and has clearance for the procedure, the requested spinal cord stimulation trial cannot be supported at this time. The request is noncertified.

TEN PHYSICAL THERAPY SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: According to the California MTUS guidelines, active therapy is based on the philosophy that a therapeutic exercise and/or activity is beneficial for restoring flexibility, strength, endurance, function, and range of motion, and for alleviating discomfort. In the case of this patient, there is no evidence of subjective or objective functional gains from previous physical therapy sessions, and the patient has undergone multiple spinal surgeries. Furthermore, the physician has failed to indicate which body part the physical therapy sessions would be for. As such, the request cannot be supported at this time and is noncertified.

ELECTRIC WHEELCHAIR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 132.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

Decision rationale: According to the California MTUS guidelines, power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by prescription of a cane or walker, if the patient has sufficient upper extremity functional to propel a manual wheelchair, or if there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Although the documentation dated 11/8/13 states that the patient has weakness in the left arm, the degree of the weakness was not specified by objective measurements. There was also no indication that the patient does not have a caregiver who is unable assist the patient in pushing a manual wheelchair on an as needed basis. Therefore, without having a thorough rationale for the medical necessity for an electric wheelchair, the requested service cannot be supported at this time. The request is noncertified.