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| Case Number: | CM14-0000339 | | |
| Date Assigned: | 01/10/2014 | Date of Injury: | 04/09/2011 |
| Decision Date: | 06/19/2014 | UR Denial Date: | 12/06/2013 |
| Priority: | Standard | Application Received: | 01/02/2014 |

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 & Rehabilitation, 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:

The patient is a 53-year-old female who has filed a claim for lumbar spinal stenosis associated with an industrial injury date of April 09, 2011. Review of progress notes reports frequent left shoulder dislocation, back pain with spasm, severe headaches, and giving out of the left leg. Patient has difficulty walking and has limited mobility; patient uses a cane to support walking. Patient also experiences symptoms of anxiety and depression. Findings include tenderness and left shoulder guarding upon range of motion. Cervical MRI from November 26, 2012 showed multilevel disc protrusions causing indentation of the thecal sac, and mild neuroforaminal narrowing at the left C3-4. Left shoulder MRI showed post-acromioplasty changes and irregularities along the anterior glenoid labrum. Electrodiagnostic study of the left upper extremity done in March 2013 was normal. Treatment to date has included muscle relaxants, opioids, sedatives, Prilosec, psychotherapy, and left shoulder surgeries in July 2012 and August 2013. Patient is currently on OxyContin 60mg, Flexeril 10mg, Percocet 10/325mg 8 per day, Xanax 0.5mg, Prilosec 20mg, and bowel regimen. Utilization review from December 06, 2013 denied the request for a trial of intrathecal pain pump, and power scooter E1230. Reasons for denial were not indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRIAL INTRATHECAL PAIN PUMP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, IMPLANTABLE DRUG-DELIVERY SYSTEMS (IDDSs), 53-54

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines pages Page(s): 52-54.

Decision rationale: According to pages 52-54 of CA MTUS Chronic Pain Medical Treatment Guidelines, implantable drug-delivery systems (IDDSs) are recommended only as an end-stage treatment alternative for selected patients with chronic intractable pain after failure of at least 6 months of less invasive methods. Other criteria for use include objective documentation of pathology, surgical intervention is not indicated or likely to be effective, psychological evaluation states that benefit would occur with implantation despite any psychiatric comorbidity, and following a successful temporary trial. In this case, there is documentation that the patient's pain symptoms are not managed well with oral medications. However, there is discussion regarding left shoulder surgery, which the patient is not currently interested in. Moreover, there are no available comprehensive objective findings referable to the low back and lower extremities. The guideline criteria were not met. Therefore, the request for a trial of an intrathecal pain pump was not medically necessary per the guideline recommendations of CA MTUS.

POWER SCOOTER E1230: 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), Knee & Leg (updated 11/21/13), Power mobility devices (PMDs).

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

Decision rationale: According to page 99 of CA MTUS Chronic Pain Medical Treatment Guidelines, power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker. These are not recommended if the patient has sufficient upper extremity function to propel a manual wheelchair, or if there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. In this case, there is documentation of episodes of instability while walking due to giving out of the left leg, causing a tendency to fall. Patient notes difficulty walking and limited mobility. Patient uses a cane to support walking. However, there is no discussion concerning equipment that would decrease this patient's activity level. Therefore, the request for power scooter E1230 was not medically necessary per the guideline recommendations of CA MTUS.

