

Case Number:	CM14-0011446		
Date Assigned:	03/05/2014	Date of Injury:	10/07/2009
Decision Date:	06/30/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	01/28/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 55 year old male whose date of injury is 10/07/2009. The mechanism of injury is described as stepping out of an RV to the lower parking lot with a straight leg. However, progress report dated 02/05/14 indicates that the injured worker sustained injuries secondary to cumulative trauma. The injured worker is status post L4-5 fusion on 03/08/10. The injured worker complains of low back pain. Medications include Diclofenac, Zyrtec, Norco, Neurontin, Pamelor, Protonix and Ambien. On physical examination lumbar range of motion is limited. Straight leg raising is moderately positive at L5 and bilateral S1. There is diminished sensation along the bilateral L5 and S1 root distribution. Diagnoses are post lumbar laminectomy syndrome, lumbar radiculopathy, lumbar spinal stenosis, IVD disorder with myelopathy, depressive disorder, pain in joint lower leg, lumbar spondylosis, lumbar degenerative disc disease, and gait instability. The injured worker has been determined to have reached maximum medical improvement. Psychological evaluation dated 09/09/13 indicates that MMPI profile may reflect over-reporting of symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

UROLOGICAL CONSULTATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127

Decision rationale: Based on the clinical information provided and American College of Occupational and Environmental Medicine (ACOEM) guidelines, the request for urological consultation is not recommended as medically necessary. The submitted records indicate that urological consultation has been recommended because of stool incontinence and sexual dysfunction; this is indicated to rule out cauda equina syndrome. However, there is no indication that there are any new physical examination findings to support the requested consultation. There is no current, detailed physical examination submitted for review.

GASTROINTESTINAL CONSULTATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127

Decision rationale: Based on the clinical information provided and American College of Occupational and Environmental Medicine (ACOEM) guidelines, the request for gastrointestinal consultation is not recommended as medically necessary. The submitted records indicate that consultation has been recommended because of stool incontinence to address sphincter dysfunction. However, there is no indication that there are any new physical examination findings to support the requested consultation. There is no current, detailed physical examination submitted for review.

SIX TO TEN INDIVIDUAL PSYCHOTHERAPY SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23.

Decision rationale: Based on the clinical information provided, the request for six to ten individual psychotherapy sessions is not recommended as medically necessary. The submitted psychological evaluation is over 6 months old. There is no current evaluation or testing measures submitted for review with a working diagnosis and individualized treatment plan for this injured worker. Additionally, the request is excessive as Chronic Pain Medical Treatment Guidelines would support an initial trial of 3-4 individual psychotherapy sessions, not 6-10.

NEUROSURGERY CONSULTATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127

Decision rationale: Based on the clinical information provided, the request for neurosurgery consultation is not recommended as medically necessary. There is no current, detailed physical examination submitted for review and no clear rationale is provided to support neurosurgery consultation at this time. It is unclear how the consultation will aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work as required by American College of Occupational and Environmental Medicine (ACOEM) guidelines.

QUAD CANE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: Based on the clinical information provided and Official Disability Guidelines (ODG), the request for quad cane is not recommended as medically necessary. The submitted records indicate that the injured worker currently utilizes a quad cane. Therefore, it is unclear why a quad cane is being requested at this time.

WHEELED WALKER WITH A SEAT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: Based on the clinical information provided and Official Disability Guidelines (ODG), the request for wheeled walker with seat is not recommended as medically necessary. The submitted records indicate that the injured worker is currently capable of ambulation with the assistance of a quad cane. Therefore, there is no clear rationale provided to support a quad cane.

TENS UNIT FOR HOME USE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: Based on the clinical information provided, the request for transcutaneous electrical nerve stimulation (TENS) unit for home use is not recommended as medically necessary. The submitted records fail to establish that the injured worker has undergone a successful trial of TENS to establish efficacy of treatment as required by Chronic Pain Medical Treatment Guidelines. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals were provided.