

Case Number:	CM14-0025250		
Date Assigned:	06/11/2014	Date of Injury:	02/18/2009
Decision Date:	09/29/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/27/2014

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 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 injured worker is a 46-year-old male with a reported date of injury on 02/18/2009. The mechanism of injury was not submitted within the medical records. His diagnoses were noted to include lumbar disc displacement without myelopathy, lumbago, and thoracic or lumbosacral neuritis or radiculitis. His previous treatments were noted to include psychotropic medication management and psychotherapy sessions. The progress note dated 01/21/2014 revealed complaints of a deep sorrowful feeling and increased anxiety. The injured worker denied suicidal ideations and reported he was feeling hopeless. The injured worker reported his back pain had increased and locked up and he saw a chiropractor that helped his neck and upper back immediately for a few days and then the pain returned to normal. The injured worker indicated that Norco was less effective and his pain level was 7/10 and he was taking an average of 6 a day. The injured worker complained of a dull ache to his left lower back and radiating pain to his left leg and foot. The physical examination of the lumbar spine revealed a restricted range of motion with flexion limited to 45 degrees, extension was limited to 15 degrees, right lateral bending was limited to 20 degrees, left lateral bending was limited to 20 degrees, and left/right lateral rotation was limited to 20 degrees. Neck movements were painful with flexion beyond 25 degrees and extension beyond 5 degrees. On examination of the paravertebral muscles, tenderness was noted on both sides and all lower extremities reflexes were equal and symmetric. The heel and toe walk was normal and the straight leg raise test was positive. The provider indicated the heel/toe walk was abnormal (radicular pain down the left leg) with decreased sensation to the stimulus on the left lateral lower leg and lower extremity weakness on the left side. The progress note dated 05/28/2014 revealed complaints of withdrawal symptoms, weight gain, back pain rated 6/10, and worsened depression and emotional eating. The physical examination of the lumbar spine revealed restriction with flexion limited to 45 degrees, extension

was limited to 15 degrees, right lateral bending was limited to 20 degrees, left lateral bending was limited to 20 degrees, lateral rotation to the left was to 20 degrees, and lateral rotation to the right was limited to 20 degrees. Neck movements were painful with flexion beyond 25 degrees and extension beyond 5 degrees. Upon examination of the paravertebral muscles, there was tenderness noted on both sides. All lower extremity reflexes were equal and symmetric and no spinal process tenderness was noted. The heel and toe walk was normal and the straight leg raise test was positive. The Faber's test was also noted to be positive. The psychiatric evaluation revealed depression and anxiety. The injured worker revealed he was worried but he didn't have any delusions or suicidal ideations. The provider indicated the heel/toe walk was abnormal (with radicular pain down the left leg) and there was decreased sensation to stimulus on the left lateral lower leg. The provider indicated the injured worker needed a motorized scooter and private room for the treatment center because his weight and pain level limited the distances he could walk. The provider indicated the injured worker needed a private room due to his sleep apnea. The Request for Authorization form dated 03/14/2014 was for a scooter for mobility and a private room due to the use of the CPAP machine and social anxiety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Private room for 45 days IP @ [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 30-32.

Decision rationale: The request for a private room for 45 days inpatient at [REDACTED] is not medically necessary. The injured worker requests a private room due to sleep apnea and his CPAP machine. The California Chronic Pain Medical Treatment Guidelines recommend chronic pain programs when there is access to programs with proven successful outcomes, for patients with conditions that put them at risk for delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria. 1 of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is a lack of an appropriate screening tool to help to determine who would most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. The negative predictors of efficacy of treatment with the program as well as negative predictors of completion of the programs are a negative relationship with the employer/supervisor, poor work satisfaction, a negative outlook about future employment, high levels of psychosocial distress (higher for treatment levels of depression, pain, and disability), involvement in financial disability disputes, greater rates of smoking, duration of prereferral disability time, prevalence of opioid use, and pretreatment levels of pain. The inpatient pain rehabilitation programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who don't have the minimal functional capacity to participate effectively in an outpatient program, have medical conditions that require more intensive oversight, are receiving large

amounts of medications necessitating medication weaning or detoxification, or have complex medical or psychological diagnoses that benefit from more intensive observation and/or additional consultation during the rehabilitation process. The Guidelines state treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. There is documentation with current measurable functional deficits and psychiatric issues; however, the request for 45 days exceeds Guideline recommendations. Although it is noted the injured worker has sleep apnea, this is not a condition that would require a private room versus a semi-private room. There is a lack of documentation regarding the medical necessity for a private room. Therefore, the request is not medically necessary.

Electric Scooter rental times 45 days IP stay @ [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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, Power Mobility Devices.

Decision rationale: The request for an electric scooter rental x45 days for inpatient stay at [REDACTED] is not medically necessary. The injured worker has an antalgic gait and radicular pain to the lower extremities. The Official Disability Guidelines do not recommend power mobility devices if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker; or the patient has sufficient upper extremity function to propel a manual wheelchair; or 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. There is a lack of documentation regarding the injured worker unable to ambulate or utilize a manual wheelchair. There is conflicting evidence regarding the injured worker's heel/toe walk due to radicular pain. There is a lack of documentation regarding assistive devices such as a cane to assist with ambulation or lack thereof to warrant an electric scooter. Therefore, the request is not medically necessary.