

<b>Case Number:</b>	CM14-0030871		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	09/25/2003
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	03/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2014

### 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 Anesthesiology, 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 36 year old male who reported an injury to his low back when he was stacking 200 lbs. worth of tile on a pallet. The clinical note dated 11/14/13 indicates the injured worker complaining of chronic pain with additional findings consistent with depression and anxiety. The injured worker also reported sleep disturbances with apprehension and restlessness. The injured worker was recommended for cognitive behavioral therapy for 12 weeks at that time. The clinical note dated 01/29/14 indicates the injured worker complaining of low back pain. The note indicates the injured worker having previously undergone an L5-S1 fusion in 2008. However, the injured worker reported ongoing constant low back pain with associated sexual difficulties. The injured worker also reported difficulty with ambulation. The note indicates the injured worker having a positive straight leg raise at 80 degrees. The utilization review dated 01/06/14 resulted in a denial for a liver function test, motorized cart, and transportation as no information had been submitted regarding the need for a liver function test as it relates to the injured worker's overall treatment plan. Additionally, no information was submitted regarding the injured workers need for a powered mobility device or the need for transportation to and from appointments.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Liver function tests:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institutes of Health.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: 1.)Fischbach FT, Dunning MB III, eds. (2009). Manual of Laboratory and Diagnostic Tests, 8th ed. Philadelphia: Lippincott Williams and Wilkins.2.)Pagana KD, Pagana TJ (2010). Mosby's Manual of Diagnostic and Laboratory Tests, 4th ed. St. Louis: Mosby Elsevier.

**Decision rationale:** The request for a liver function test is not medically necessary. The documentation indicates the injured worker complaining of low back pain with associated symptoms including depression, anxiety, and apprehension. A liver function test is indicated for injured workers who have demonstrated a compromise of the liver function. No information was submitted regarding the injured worker's liver involvement. Without this information in place, it is unclear if the injured worker would benefit from an additional liver function test. Additionally, no information was submitted regarding the need for the test in order to provide sufficient coverage of care. Therefore, this request is not indicated as medically necessary.

**Motorized cart:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institutes of Health.

**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, Power mobility devices (PMDs).

**Decision rationale:** A motorized cart is indicated for injured workers who have demonstrated significant functional deficits regarding the use of a manual wheelchair. No information was submitted regarding the injured worker's significant strength deficits in the upper extremities or inability to propel a manual wheelchair. Therefore, this request is not indicated as medically necessary.

**Transportation for visit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institutes of Health.

**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, Transportation (to & from appointments).

**Decision rationale:** The request for transportation for visits is not medically necessary. No information was submitted regarding the injured worker's inability to drive an automobile or to utilize public transportation. Without this information in place, it is unclear if the injured worker requires additional transportation to visits.

