

Case Number:	CM14-0079975		
Date Assigned:	07/18/2014	Date of Injury:	01/10/2008
Decision Date:	09/09/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	05/30/2014

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 Management, 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:

According to the records made available for review, this is a 70-year-old male with a 1/10/08 date of injury. At the time (5/5/14) of request for authorization for Referral to pulmonologist and Motorized scooter, there is documentation of subjective (mid and low back pain radiating to bilateral hips, anterior and lateral thighs, shins and feet with numbness) and objective findings (antalgic gait, tenderness over the bilateral lumbar spines, and normal lordosis), imaging findings (reported chest x-ray (6/26/09) revealed no acute cardiopulmonary disease is demonstrated; report not available for review), current diagnoses (L2-S1 spondylosis, L2-S1 facet arthropathy, L3-S1 stenosis, and intermittent lumbar radiculopathy), and treatment to date (medications, epidural steroid injections, and radiofrequency ablation).

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to pulmonologist: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

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) Independent Medical Examinations and consultations, page(s) 127.

Decision rationale: The MTUS reference to ACOEM guidelines identifies that consultation is indicated to 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 criteria necessary to support the medical necessity to support the medical necessity of consultation. Within the medical information available for review, there is documentation of diagnoses of L2-S1 spondylosis, L2-S1 facet arthropathy, L3-S1 stenosis, and intermittent lumbar radiculopathy. In addition, given documentation of a rationale identifying a referral to pulmonologist to determine causation and apportionment of lung findings in pulmonary function test, there is documentation that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, and permanent residual loss. Therefore, based on guidelines and a review of the evidence, the request is medically necessary.

Motorized scooter: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of a functional mobility deficit that cannot be sufficiently resolved by the prescription of a cane or walker, the patient has insufficient upper extremity function to propel a manual wheelchair, and there is no caregiver who is available, willing, or able to provide assistance with a manual wheelchair, as criteria necessary to support the medical necessity of Motorized Wheelchair or Scooter. Within the medical information available for review, there is documentation of diagnoses of L2-S1 spondylosis, L2-S1 facet arthropathy, L3-S1 stenosis, and intermittent lumbar radiculopathy. In addition, despite documentation that the patient has trouble walking greater than 5 minutes with severe onset of pain, limiting his ability to perform activities of daily living, there is no documentation of a functional mobility deficit that cannot be sufficiently resolved by the prescription of a cane or walker, the patient has insufficient upper extremity function to propel a manual wheelchair, and there is no caregiver who is available, willing, or able to provide assistance with a manual wheelchair. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.