

<b>Case Number:</b>	CM14-0131151		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	05/07/2014
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	07/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 37-year-old female who has submitted a claim for osteoarthritis of the acromioclavicular joint, tendinosis of the infraspinatus and supraspinatus, left elbow bursitis, lumbar spine sprain/strain, facet arthropathy at L4-L5 and L5-S1, lumbar disc herniation and lumbar radiculopathy associated with an industrial injury date of 5/7/2014. Medical records from 2014 were reviewed. The patient complained of low back pain and right elbow pain. Range of motion of the lumbar spine and right elbow was limited. Tenderness and trigger points were noted at the lumbar spine. Sensation was diminished at the right foot. Treatment to date has included lumbar epidural steroid injection, chiropractic care, physical therapy and medications. The utilization review from 7/19/2014 denied the request for transportation: frequency and duration not indicated. Reasons for denial were not made available.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transportation: Frequency and Duration not indicated: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines TWC Knee and Leg Procedure Summary Update 06/05/2014.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Transportation (To and From Appointments).

**Decision rationale:** CA MTUS does not specifically address transportation. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that transportation is recommended for medically necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. In this case, there is no documented rationale concerning need for transportation assistance. There is likewise no discussion concerning absence of a caregiver to warrant such. The medical necessity cannot be established due to insufficient information. There is no clear indication for certifying transportation at this time. Moreover, the present request as submitted failed to specify the frequency and duration. Therefore, the request for transportation: frequency and duration not indicated is not medically necessary.