

Case Number:	CM15-0033536		
Date Assigned:	02/27/2015	Date of Injury:	03/07/2003
Decision Date:	04/09/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	02/23/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

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 63 year old male with an industrial injury date of 03/27/2003. He presents for follow up on 01/14/2015 with complaints of constant pain in his cervical spine and headaches. The patient has had mild weakness in UE with numbness, tingling and paresthesias- The neck pain was radiating to shoulders. He also notes some pain in his low back. Physical exam noted spinous process tenderness at the cervical 4 level and limited range of motion. There was moderate guarding of movement and moderate trapezius spasm and tenderness, weakness of the bilateral shoulder. Physical examination of the lumbar spine revealed limited range of motion, tenderness on palpation, positive SLR, decreased strength and sensation in LE. The provider documents the injured worker is unable to sit or stand for a long period of time. The notes stated that he has difficulty with control of his legs because of his pain and therefore is unable to drive himself. Prior treatments include diagnostics, surgery and medications.

Diagnoses: Status post decompression laminectomy and discectomy lumbar 4-5 and lumbar 5-sacral 1 with pedicle screw fixation, iliac graft interbody fusion, Herniated lumbar disc lumbar 4-5 and lumbar 5- sacral 1 with bilateral facet arthropathy at lumbar 4-5 and lumbar 5- sacral 1- Status post repair of pseudoarthrosis with pedicle screw fixation, iliac graft lumbar 4 to the sacrum- Status post decompression, laminectomy and fusion of lumbar 2-3 with posterolateral fusion, bone graft and pedicle screw fixation, August 2014. The patient has had X-ray of the cervical and lumbar spine that revealed post surgical changes and MRI of the cervical spine that revealed disc bulges at C4-5- The medication list include norco, Soma, glipizide, aspirin and Ambien. The patient has used a lumbar brace for this injury. The patient's surgical history

include neck surgery in 2007, left shoulder surgery in 1997, left big toe surgery and back surgery in 1/29/13- Patient has received an unspecified number of PT visits for this injury

IMR ISSUES, DECISIONS AND RATIONALES

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

Transportation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Department of Healthcare Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (updated 02/27/15) Transportation (to & from appointments).

Decision rationale: Transportation as per records provided patient underwent decompression, laminectomy and fusion of lumbar 2-3 with posterolateral fusion, bone graft and pedicle screw fixation, August 2014. Details of the post op treatment were not specified in the records provided. Any evidence that the patient had not recovered from the surgery was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Consistent objective evidence that the patient has functional deficits that prevent him from ambulating and arranging for his own transportation to the medical appointments is not specified in the records provided. Response to these therapies and previous therapy notes were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. The rationale for the need for helping the patient to arrange for continued transportation was not specified in the records provided. The medical necessity of the request for Transportation is not fully established in this patient.