

Case Number:	CM13-0023421		
Date Assigned:	10/11/2013	Date of Injury:	05/07/2007
Decision Date:	04/17/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	09/12/2013

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 Family Practice, 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 patient is a 51-year-old male who reported an injury on 05/07/2011. The mechanism of injury was not stated. The patient is diagnosed with cervical/lumbar discopathy, status post left L5-S1 L&D, rule out internal derangement of the right shoulder, and rule out internal derangement of the right elbow. The most recent physician progress report submitted for this review is documented on 08/19/2013 by [REDACTED]. The patient reported ongoing pain to the cervical spine and right upper extremity, as well as the lumbar spine. Physical examination revealed tenderness to palpation with spasm of the cervical spine, positive axial loading compression testing and Spurling's maneuver, painful and restricted range of motion, and dysesthesia at the C5 to C7 dermatomes. The patient also demonstrated tenderness to palpation with positive Hawkins and impingement testing of the right shoulder, tenderness to the right elbow, and tenderness to palpation with spasm in the lumbar spine, positive straight leg raising, and dysesthesia. A urine specimen was obtained on that date. An unknown procedure was performed in the office on that date. Treatment recommendations are not stated.

IMR ISSUES, DECISIONS AND RATIONALES

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

REFERRAL WITH PSYCHIATRIST FOR CONSULT AND TREAT FOR DEPRESSION

[REDACTED] RFA 8/27/13): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF

OCCUPATIONAL AND ENVIRONMENTAL MEDICINE 2ND EDITION (2004), 15, PAGE 398.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, CORNERSTONES OF DISABILITY PREVENTION AND MANAGEMENT, PAGE 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As per the documentation submitted, the patient does not report depressive symptoms. There is no psychological examination provided for review. The medical necessity for the requested referral has not been established. As such, the request is non-certified.

TRAMADOL ER 150MG #90 ONE TAB QD (██████████ RFA 8/2/713): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain over multiple areas of the body. Satisfactory response to treatment has not been indicated. Therefore, the request is non-certified.

LEVOFLOXACIN TABLETS 750MG #20 (██████████, RFA 8/2/713): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), INFECTIOUS DISEASE CHAPTER, LEVOFLOXACIN (LEVAQUIN).

Decision rationale: Official Disability Guidelines state Levaquin is recommended as first line treatment for osteomyelitis, chronic bronchitis, and pneumonia. The patient does not maintain any of the above mentioned diagnoses. The medical necessity for the requested medication has not been established. As such, the request is non-certified.