

Case Number:	CM13-0031071		
Date Assigned:	12/04/2013	Date of Injury:	05/20/2011
Decision Date:	02/10/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	10/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 claimant is a 27 years old male with stated date of injury of May 21, 2011. In the medical report dated August 29, 2013, the claimant complained of pain in his left lower back traveling to his knee which he describes as aching. He rates his pain as 7 on a numeric rating scale of 0-10 with 0 being no pain and 10 being most severe pain. The patient is status post his first therapeutic lumbar epidural steroid injection (CPT 62278) at disc levels L4-L5 and L5-S1 and L1 lumbar facet joint block (CPT 64442, 6444:3) At the initial assessment that the patient has had at least 50% improvement and should continue to a second therapeutic epidural steroid injection for maximum benefit. On August 29, 2013, the patient underwent his first therapeutic lumbar epidural steroid injection {CPT 62278) for 5 weeks. The procedure helped to restore ability to function to the low-back. The procedure helped reduce the patient's pain by three quarters. The pain frequency is much less than before. The patient experienced a reduction in pain that began 2 days after the procedure. He reports a reduction in pain from 8-9 to 6-7 on a numeric rating scale of to 10 and the lowest level of pain lasted. The treating physician recommended that the patient undergo his second therapeutic lumbar epidural steroid injection (CPT 62278) at disc levels L4-L5 and L5-S 1. After the first therapeutic lumbar epidural steroid injection, the patient has been able to reduce his pain medications. His pain has decreased by at least 50%. He demonstrates increased range of motion and has reported improved function or activities of daily living. Overall, it is my assessment that the patient has had at least 50% improvement and should continue to a second therapeutic epidural steroid injection for maximum benefit. Based on these findings, I am recommending the patient undergo a lumbar facet joint block (CPT 64442, 64443) at the medial branch at levels L3-L4, L4-L5 and L5-S 1 bilaterally. If there is successful axia

IMR ISSUES, DECISIONS AND RATIONALES

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

Internal Medicine: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 92. Decision based on Non-MTUS Citation The role of the medical consultant Steven L. Cohn, MD, FACP* Division of General Internal Medicine, State University of New York, Downstate Medical Center, Brooklyn, NY, USA Medical Consultation Service, Kings County Hospital, Brooklyn, NY, USA Published in The Me

Decision rationale: CA MTUS: According to ACOEM guidelines, page 92, referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. The guideline further stated in page 127, "the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial facts are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment may also be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification ... A referral may be for. (1) Consultation: 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. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. (2) Independent Medical Examination (I ME): to provide medico legal documentation of fact, analysis, and well-reasoned opinion, sometimes including analysis of causality. Also, according an article published in the Medical Clinic of North America Journal, titled "The role of the Medical Consultant": Internists as well as sub-specialists are often asked to evaluate a patient prior to surgery. Many primary care physicians, however, feel inadequately trained to function as consultants for preoperative medical evaluations [1]. Additionally, a recent survey of hospitalists found preoperative medical consultation to be an area of importance and one in which the hospitalists felt a need for additional training [2]. Much of the literature on perioperative medicine and medical consultation has been scattered among different disciplines, and only recently has this information appeared in medical journals and textbooks typically read by internists. The role of the preoperative medical consultant is to identify and evaluate a patient's current medical status and provide a clinical risk profile, to decide whether further tests are indicated prior to surgery, and to optimize the patient's medical condition in an attempt to reduce the risk of complications. Knowledge of medical illnesses that influence surgical risk, an understanding of the surgical procedure, effective communication and interaction with the other members of the preoperative team, and integration of a management plan are crucial for the medical consultant. Therefore the request for pre-operative Internal Medicine Consultation is medically necessary.