

Case Number:	CM13-0048829		
Date Assigned:	12/27/2013	Date of Injury:	04/01/2011
Decision Date:	03/06/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	11/06/2013

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 Physical Medicine and Rehabilitation, and is licensed to practice in Oklahoma and 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 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 patient is a 34-year-old male who reported an injury on 4/1/11. The patient was diagnosed with a herniated disc at C3-6, a herniated disc at L4-S1, a thoracic spine sprain/strain, left TMJ syndrome, posttraumatic photophobia, cephalgia, right carpal tunnel syndrome, and anxiety with depression. The patient was seen by [REDACTED] on 6/11/13. He reported ongoing pain in the bilateral TMJ, shoulders, and lower back. Physical examination revealed decreased range of motion with spasms in the cervical and lumbar spine, positive tenderness to palpation at the bilateral TMJ, positive straight leg raise and positive Kemp's testing. Treatment recommendations included a referral to pain management for a lumbar epidural steroid injection and medication refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic follow-up: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The California MTUS/ACOEM practice guidelines state that physician follow-up can occur when a release to modified, increased or full duty is needed, or after appreciable healing or recovery can be expected. Physician follow-up might be expected every 4-7 days if the patient is off work, or 7-14 days if the patient is working. As per the documentation submitted, there is no significant change in the patient's physical examination. There was also no indication of a progression or worsening of symptoms. There was no evidence of any plans for surgical intervention in the future. The patient's current functional deficits were not clearly outlined. A specific treatment plan with short-term and long-term goals has not been provided. The medical necessity for the requested follow-up visit has not been established; therefore, the request is non-certified.

Pain management referral for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 88-92.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state that a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or if there is difficulty obtaining information or agreeing to a treatment plan. As per the documentation submitted, the patient has been referred to pain management for a lumbar epidural steroid injection; however, there is no evidence of a recent failure to respond to conservative treatment. There were also no imaging studies or electrodiagnostic reports submitted for review to corroborate a diagnosis of radiculopathy. The medical necessity for the requested service has not been established; therefore, the request is non-certified.

Medication refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60-61.

Decision rationale: The California MTUS Guidelines state that medications for chronic pain are recommended for specific indications. Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. As per the documentation submitted, the patient has continuously utilized opioid medications, muscle relaxants and topical analgesics. However, despite the ongoing use, the patient continues to report persistent pain with activity limitations. There was no change in the patient's physical examination to indicate functional improvement. Additionally, the name of the drug, the dosage,

and the frequency and duration were not provided in the request. Based on the clinical information received, the request is non-certified.