MAXIMUS Federal Services

Case Number:	CM13-0049334		
Date Assigned:	12/27/2013	Date of Injury:	10/29/2003
Decision Date:	03/27/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/07/2013

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 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 49-year-old male who reported an injury on 10/29/2003. The mechanism of injury was not specifically stated. The patient is currently diagnosed with cervical disc herniation with radiculitis/radiculopathy, right shoulder tendonitis and impingement syndrome, cubital tunnel syndrome on the right, lateral epicondylitis on the right, lumbar disc herniation with radiculitis/radiculopathy, anxiety and depression, and insomnia. The patient was seen by [redacted] on 09/05/2013. The patient reported low back pain with radiation to bilateral lower extremities. Physical examination revealed paraspinal spasm, positive straight leg raising bilaterally, hypoesthesia at the anterolateral aspect of the foot and ankle, and weakness. Treatment recommendations included a discogram of the lumbar spine at L2-S1, an internal medicine evaluation for surgical clearance, a Functional Capacity Assessment, psychological evaluation, physical therapy twice per week for 6 weeks, and continuation of current medications with the addition of Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Discogram lumbar spine L2-3, L3-4, L4-5, and L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation In. Harris J (Ed), Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 303-305; Official Disability Guidelines (ODG) Low Back Chapter, Discography.

Decision rationale: California MTUS/ACOEM Practice Guidelines state recent studies on discography do not support its use as a preoperative indication for either intradiscal electrothermal annuloplasty or fusion. Discography does not identify the symptomatic high intensity zone. Discography may be used where fusion is a realistic consideration, and may provide supplemental information prior to surgery. Official Disability Guidelines state discography is not recommended. As per the documentation submitted, there is no evidence of a recent failure of recommended conservative treatment including active physical therapy. There is no documentation of a detailed psychosocial assessment. Based on the clinical information received, the request is non-certified.

X-ray or CT Scan: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation In. Harris J (Ed), Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 303-305.

Decision rationale: California MTUS/ACOEM Practice Guidelines state lumbar x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. As per the documentation submitted, the patient had previously undergone x-rays of the lumbar spine. Documentation of a significant change in the patient's symptoms or physical examination findings was not provided for review. Therefore, the medical necessity for additional x-rays has not been established. As such, the request is non-certified.

Internal Medicine Evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation In. Harris J (Ed), Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 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 the patient's discography procedure has not been authorized, the concurrent request for a referral consultation is also not medically necessary. Therefore, the request is non-certified.

Functional Capacity Evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation In. Harris J (Ed), Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 89-92; Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available including Functional Capacity Examination when reassessing function and functional recovery. Official Disability Guidelines state a functional capacity evaluation may be considered if case management is hampered by complex issues, and the timing is appropriate. As per the documentation submitted, there is no evidence of previous unsuccessful return to work attempts. There is no evidence that the patient has reached or is close to maximum medical improvement. There is also no documentation of a defined return to work goal or job plan. Based on the clinical information received, the request is non-certified.

Psychiatric clearance for the Discogram procedure: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation In. Harris J (Ed), Occupational Medicine Practice Guidelines, 2nd Edition (2004) - pp. 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 the patient's discography procedure has not been authorized, the concurrent request for a referral consultation is also not medically necessary. Therefore, the request is non-certified.

Physical therapy 2x6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Physical Medicine Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow

for a fading of treatment frequency plus active self-directed home physical medicine. The current request for 12 sessions of physical therapy exceeds guideline recommendations for a total duration of treatment. Based on the clinical information received, the request is non-certified.

Ambien 10mg, QTY 30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. There is no documentation of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. As guidelines do not recommend long-term use of this medication, the current request is not medically appropriate. As such, the request is non-certified.

Norco 10/325mg, QTY120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Opioids 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 assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized opioid medication. Despite ongoing use, the patient continues to report persistent pain. Satisfactory response to treatment has not been indicated by decrease in pain level, increase in function, or improved quality of life. Therefore, the request is non-certified.

Ultram 50mg, QTY60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Opioids 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 assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized opioid medication. Despite ongoing use, the patient continues to report persistent pain. Satisfactory response to treatment has not been indicated by decrease in pain level, increase in function, or improved quality of life. Therefore, the request is non-certified.

Antivert 50mg, QTY 60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Physician Reviewer based his/her decision on the California MTUS/ACOEM Practice Guidelines did not specifically address the requested medication; Official Disability Guidelines did not specifically address the requested medication. www.rxlist.com, Copyright

Decision rationale: Antivert is an antihistamine that is used to treat or prevent nausea, vomiting, and dizziness caused by motion sickness. None of the aforementioned conditions have been described or diagnosed in this patient. Therefore, the medical necessity has not been established. As such, the request is non-certified.