

<b>Case Number:</b>	CM14-0007869		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	04/27/2011
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	01/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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 3 reviewer is Board Certified in Occupational Medicine 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 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 38 year old male who has submitted a claim for recurrent left L5 radiculopathy status post lumbar decompression associated with an industrial injury date of April 27, 2011. Medical records from 2012-2013 were reviewed. The patient complained of low back pain. Physical examination showed tenderness over the lumbar paraspinal muscles. Range of motion was normal. There was diminished sensation noted over the left L5 dermatome. Straight leg raise was negative. Motor strength was intact. An MRI of the cervical spine, dated March 4, 2013, revealed disc desiccation at C2-C3 down to C5-C6, and reversal of normal cervical lordosis with decreased range of motion on flexion and extension which may reflect an element of myospasm. An MRI of the lumbar spine, dated June, 7, 2013, showed straightening of the normal lumbar lordotic curvature, disc desiccation with loss of height of L4-L5 intervertebral disc, left paracentral annular fissure at the L3-L4 intervertebral disc, and diffuse disc herniation measuring 3.5mm posteriorly pre axial loading and 3.5 mm post axial loading which causes bilateral neural foraminal stenosis and spinal canal stenosis. Treatment to date has included medications, physical therapy, home exercise program, activity modification, L4-L5 laminectomy with bilateral medial facetectomy and foraminotomies. A utilization review dated January 6, 2014 denied the request for medication management sessions per DWC form dated 12/17/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **MEDICATION MANAGEMENT SESSIONS PER DWC FORM DATED 12/17/13:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Office Visits.

**Decision rationale:** As stated on page 405 of the MTUS ACOEM Guidelines, frequency of follow-up visits may be determined by the severity of symptoms, whether the patient was referred for further testing and/or psychotherapy, and whether the patient is missing work. These visits allow the physician and patient to reassess all aspects of the stress model (symptoms, demands, coping mechanisms, and other resources) and to reinforce the patient's supports and positive coping mechanisms. Generally, patients with stress-related complaints can be followed-up by a midlevel practitioner every few days for counseling about coping mechanisms, medication use, activity modifications, and other concerns. The ODG states that the determination of clinical office visit is based on which medications the patient is taking, since some medicines such as opiates, among others, require close monitoring. In this case, the patient was diagnosed with adjustment disorder with mixed anxiety and depressed mood. A medication management is appropriate and necessary in order to establish and monitor the patient's medication regimen. However, there was no mention of any medication that the patient was taking from the medical records submitted. There is no medication history that was documented. In addition, the most recent progress report was dated June 2013. The current clinical functional status of the patient is unknown. The rationale of the present request was not provided. As such, the request is not medically necessary and appropriate.