

Case Number:	CM14-0011513		
Date Assigned:	04/23/2014	Date of Injury:	09/08/2009
Decision Date:	08/12/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	01/29/2014

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 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 42-year-old male who has submitted a claim for cephalgia/blurred vision, cervical spine strain/sprain with radiculopathy; left shoulder avulsion injury with possible tear status post crush injury on left upper extremity; and reflective pain on mid and low back, sleep disturbance, depression and posttraumatic stress disorder associated with an industrial injury date of September 8, 2009. Medical records from 2013-2014 were reviewed. The patient complained of upper and lower back, and left upper extremity pain. The pain was rated at 6/10 with medications, and 10/10 without medications. There was numbness, burning and tingling sensation noted with regards to low back pain. Headache and mood changes were noted. The patient was symptomatic with depression, insomnia, and dizziness. Physical examination showed mild tenderness in the bilateral paraspinal musculature and bilateral upper trapezius musculature. Moderate tenderness was also noted on the left suprascapular and infrascapular musculature. A rigid brace was in place in the left upper extremity. Diffuse tenderness was noted on the left elbow and forearm. Significant allodynia was noted. There was mild to moderate swelling over the left forearm and left wrist. Range of motion of the left elbow was restricted. Tenderness was noted over the right shoulder and elbow with palpation. There was lumbar spine tenderness from L3 to S1. Motor strength was 4/5 on the left extensor hallucis longus. Slight hypesthesia was noted bilaterally on the L5 dermatomes. Achilles reflex was trace on the left and 2+ on the right. An MRI of the lumbar spine, dated November 28, 2013, revealed a 3-4mm disc protrusion at L5-S1. An official report of the imaging study was not available. Treatment to date has included medications, activity modification, and lumbar epidural steroid injection. A utilization review determination dated January 13, 2014, denied the request for follow-up evaluation with a pain management specialist (medications) because there was no recent report to warrant the requested follow-up visit, and no documentation of ongoing significant issues or

extenuating circumstances that would require follow-up evaluation. The request for follow up-evaluation with a psychologist/psychiatrist (sleep disturbance, anxiety, distress) was also denied. A request for Botox therapy 100 units to cervical area and 100 units on a separate occasion to frontal areas (headaches) was denied because there was limited evidence that the claimant has cervical dystonia to warrant the invasive procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

FOLLOW-UP EVALUATION WITH A PAIN MANAGEMENT SPECIALIST

(MEDICATIONS): Overturned

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) Pain Section, Office Visits.

Decision rationale: The Official Disability Guidelines, (ODG) states that evaluation and management (E&M) outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. In this case, the patient was last seen by a pain management specialist on 04/16/2014. Beneficial effects from previous epidural steroid injection were assessed. The patient was likewise prescribed pain medications. The medical necessity for follow-up has been established for monitoring of current response to therapy. Therefore, the request is medically necessary and appropriate.

FOLLOW-UP EVALUATION WITH A PSYCHOLOGIST/PSYCHIATRIST (SLEEP DISTURBANCE, ANXIETY, DISTRESS): 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) Pain Section, Office Visits.

Decision rationale: The Official Disability Guidelines, (ODG), states that evaluation and management (E&M) outpatient visits to the offices of medical doctor play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. In this case, the patient was diagnosed with depression and posttraumatic stress disorder secondary to industrial injury. The patient was authorized for 8 psychiatry sessions on May 2013. However, there was no documentation of any psychiatric evaluation. Progress reports state that patient was being treated for anxiety and depression with mood elevating medication and psychotherapy. A recent

progress report dated April 16, 2014, states that the patient remained symptomatic with depression and insomnia. Follow-up consultation may be necessary; however, the request failed to specify the quantity of office visits needed for this case. The medical necessity cannot be established due to insufficient and inconsistent information, notably as to whether the previously authorized psychiatric visits were performed, and the outcome of those visits. Therefore, the request is not medically necessary and appropriate.

BOTOX THERAPY 100 UNITS TO CERVICAL AREA: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin Page(s): 25-26.

Decision rationale: According to pages 25-26 of the MTUS Chronic Pain Guidelines, Botox is not generally recommended for chronic pain disorders but recommended for cervical dystonia. Furthermore, Botox is not recommended for tension-type headache, migraine headache, and chronic neck pain. In this case, the patient was requested to undergo Botox therapy for increasing daily headaches. The MTUS Guidelines clearly do not support Botox for headache and chronic neck pain. Moreover, the submitted medical records do not show evidence of cervical dystonia. As such, the request is not medically necessary and appropriate.