MAXIMUS Federal Services

Case Number:	CM14-0014804		
Date Assigned:	02/28/2014	Date of Injury:	01/01/1997
Decision Date:	07/21/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/05/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain 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 61-year-old female with a 1/1/97 date of injury. Most recently on 9/13/13, the patient was noted to have severe pain in the neck, low back, bilateral shoulders, and bilateral wrists, limiting daily activities. In the cervical spine there was tenderness with spasms and guarding, as well as reduced range of motion. The patient had bilateral shoulder tenderness and reduced range of motion. A left subacromial injection was performed. In addition, it was noted that the patient is very depressed and is being treated by a psychiatrist for post-traumatic stress disorder (PTSD), on a nonindustrial basis. The treating provider documented an overlap with the industrial injury that brought on depression. The treatment to date has included an epidural steroid injection, a subacromial injection, physical therapy, psychiatric treatment, activity modification, and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE CONSULTATION WITH PSYCHIATRIST: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

Decision rationale: The California MTUS states that psychological evaluations are recommended and are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. However, it is noted that the patient is already being treated by a psychiatrist for PTSD. Depression was exacerbated by the work injury. It is unclear why an additional psychiatric referral is requested for depression, when the patient is already receiving treatment. Furthermore, referrals are generally recommended when the patient's condition is beyond the treating provider's scope of practice, and lower levels of care have been attempted. There is no discussion of severe depression, suicidal ideations, or ineffectiveness of current psychiatric treatment. Therefore the request is not medically necessary.

ONE SACRO-EAST CAR SEAT PAD: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg chapter; DME.

Decision rationale: The ODG recommends DME as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. A car seat pad does not fall under the criteria of medically necessary DME, and it has not been discussed its use in regards to functional limitations. Therefore the request is not medically necessary.

60 TIZANIDINE 4 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

Decision rationale: The patient has been utilizing muscle relaxants as far back as 2011, and with a 1997 date of injury, the duration of use is not entirely clear. The California MTUS Chronic Pain Medical Treatment Guidelines recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The chronic pain treatment utilizing muscle relaxants is not generally recommended. Furthermore there is a lack of documented functional improvement or reduction in spasms attributed to the use of Tizanidine. Therefore the request is not medically necessary.