

Case Number:	CM14-0018474		
Date Assigned:	05/07/2014	Date of Injury:	10/24/2007
Decision Date:	09/05/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	02/13/2014

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 and Rehabilitation, and is licensed to practice in Nevada. 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 records presented for review indicate that this 55 year-old individual was reportedly injured on October 24, 2007. The mechanism of injury is noted as a slip and fall. The most recent progress note, dated December 2013, indicates that there are ongoing complaints of neck, bilateral upper extremity and low back pain. The physical examination demonstrated a decrease in cervical spine range of motion, a decrease in right shoulder range of motion, tenderness about the right elbow and normal upper extremity motor function. Sensory testing is intact. Diagnostic imaging studies reported the following findings of minimal disc protrusion at multiple levels in the cervical spine, a right shoulder rotator cuff tendinitis, a tendon injury of the triceps tendon, and an unremarkable lumbar spine MRI. Previous treatment includes multiple medications, injections, chiropractic care and other conservative measures. It was determined that maximum medical improvement had been reached and a 20% whole person impairment rating assigned. It is also noted that the past medical history significant for rheumatoid arthritis and fibromyalgia. A request had been made for multiple medications and was not certified in the pre-authorization process on December 27, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROZAC 40MG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) formulary chapter updated July, 2014.

Decision rationale: As outlined in the literature, this medication is a selective serotonin reuptake inhibitor. This is not addressed in the California Medical Treatment Utilization Schedule (CAMTUS). The Official Disability Guidelines parameters are used. This medication is indicated for a major depressive disorder and none has been diagnosed in this case. It is noted that there is an anxiety and depression diagnosis offered but there is no objective occasion of the presence of either of these maladies. Therefore, based on the complete lack of medical evidence the medical necessity has not been established.

NEURONTIN 600MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20,49 of 127.

Decision rationale: Gabapentin is considered a first-line treatment for neuropathic pain. Based on the clinical documentation provided, there is no evidence of neuropathic type pain or radicular pain on exam or subjectively. The presenting complaints appear to be soft tissue myofascial strain type injury only. As such, without any evidence of neuropathic type pain the medication is not medically necessary.

FIORICET: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23 of 127.

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule (CAMTUS), this medication (barbiturate containing analgesic) is not recommended for chronic pain. The potential for drug dependence, abuse and other appropriate activities is noted to be high. Furthermore, there is no evidence that the analgesic efficacy of the session medications is significant. As such, the medical necessity is not been established in the progress of presented for review.

PAIN MANAGEMENT CONSULT: 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 - Independent Medical Examinations and Consultations, pg 127.

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule (CAMTUS), a referral to a specialist is indicated if the diagnosis is "uncertain or extremely complex" and neither of these situations appear to be present. When noting the date of injury, the finding a physical examination tempered by the diagnosis offered it is clear that the exact nature of the current rally has been objectified and the issue is pain control. The most recent progress notes did not give any clinical reason why a consultation is necessary to address the current complaints offered. As such, there is no medical necessity established.

POWER MOBILITY DEVICE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99 of 127.

Decision rationale: As noted in the California Medical Treatment Utilization Schedule (CAMTUS), these devices are "not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker" or if a manual wheelchair will suffice. Mobilization and exercise is encouraged in every aspect of the treatment. As such the medical necessity for this device has not been established in the progress of presented for review.

CHIROPRACTIC TREATMENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-89 of 127.

Decision rationale: California Medical Treatment Utilization Schedule (CAMTUS) support the use of manual therapy and manipulation (chiropractic care) for low back pain as an option. A trial of 6 visits over 2 weeks with the evidence of objective functional improvement and a total of up to 18 visits over 16 weeks is supported. After review of the available medical records, there is no clinical documentation or baseline level of function to show future subjective or objective improvements with the requested treatment. In addition, when considering the date of injury, the treatment to date, the most current clinical evaluation reviewed there is no medical necessity for additional chiropractic care established.

PSYCHIATRIC TREATMENT: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental health treatment guidelines updated June, 2014.

Decision rationale: This request is overly broad and vague. There is an element of depression noted however there has not been any psychiatric evaluation completed establishing the nidus for the request. Therefore, when noting the parameters outlined in the Official Disability Guidelines, there is insufficient clinical information presented to suggest the need for psychiatric intervention or what "psychiatric care" means. Therefore, this request is not medically necessary.