

Case Number:	CM14-0153773		
Date Assigned:	09/23/2014	Date of Injury:	03/10/2014
Decision Date:	10/29/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/19/2014

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 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 52 year old female who was injured on 03/10/2014 when she slipped off a ladder, missing the last step and fell off a ladder. She sustained an injury to his right low back and hip, left shoulder, upper arm and entire leg. She has been treated with physical therapy. Prior medication history included Ultram and Meloxicam. MRI of the lumbar spine dated 05/23/2014 demonstrated mild facet joint arthritis at L4-5 with annular disc bulging causing mild lateral recess stenosis. There were no significant disk herniations or neural foraminal narrowing and there were no definite acute bony fractures. Visit note dated 05/07/2014 stated the patient presented with low back pain and pain in the left leg. She rated her pain as 10/10. She also reported pain in her right hip radiating down her right leg. On exam, she had diffuse tenderness bilaterally in the lumbar paraspinal area. Her muscle strength was normal and sensation to light touch was intact. The patient was diagnosed with radiculopathy of the lumbar spine; lumbar sprain; hip/thigh sprain and shoulder sprain. Progress report dated 06/10/2014 stated the patient complained of right hip pain. This pain was reportedly aching, sharp, and radiating down the right leg. Pain was reportedly 9/10. Condition had reportedly worsened since prior visit. Pain was aggravated by standing and walking, and alleviated by medications. Exam revealed midline lumbar and bilateral lumbar paraspinal tenderness. Deep tendon reflexes in the lower extremities were normal. Negative supine straight leg raise documented bilaterally. Waddell's sign was positive for superficial tenderness. Patrick's test negative bilaterally. Sensation to light touch was intact to the bilateral lower extremities. Normal muscle strength in tested muscle groups of the lower extremities was noted. Forward flexion was 60 degrees, extension and bilateral lateral bending were normal. Rotation was normal bilaterally. Normal heel-toe gait was documented, with no gait antalgic. No tenderness was noted about the left shoulder. Shoulder ROM was preserved but active motion above shoulder height was avoided during exam. Neck ROM was

preserved. No pain with external rotator stressing actively or passively. Inconsistent strength testing noted. DTRs in the bilateral upper extremities were preserved and symmetric. Listed diagnoses included radiculopathy of the lumbar or thoracic spine, sprain of the lumbar region, sprain of the hip/thigh, sprain of the shoulder/arm. A recommendation was made that the patient be evaluated by a pain management specialist, with the justification listed as, "Subjective complaints do not match the objective finding or the MRI." Progress report dated 08/14/2014 noted the patient presented with complaints of lower back pain. Condition reportedly unimproved from prior visit. Pain was 3/10, constant, aching and sharp. Pain was reportedly aggravated by bending, lifting, walking, and weight bearing. Pain was reportedly alleviated by application of cold compresses on her pain sight. Exam revealed midline tenderness at the lumbar spine. Lumbar paraspinal tenderness was reported bilaterally, along with sacral area tenderness. Deep tendon reflexes were normal and symmetric in the lower extremities. Muscle strength was normal in both lower extremities in the muscle groups tested. Back range of motion showed flexion to be 60 degrees, extension at 15 degrees, lateral bending 15 degrees bilaterally. Patient was noted to be sitting on the right side during the exam. Gait was stiff. Listed diagnoses included radiculopathy of lumbar or thoracic spine, sprain of the lumbar region, sprain of the hip/thigh, and sprain of the shoulder/arm. Meloxicam was refilled, as was tramadol. Prior utilization review dated 08/20/2014 states the request for Pain Management consult was denied as medical necessity had not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management consult: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127. Decision based on Non-MTUS Citation Official Disabilities Guidelines (ODG), Pain, Office Visits

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, page(s) 503-542

Decision rationale: The American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) notes that patient's may be referred to specialists when the diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation may aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness to return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. Medical records document findings which suggest pain out of proportion to objective examination and imaging findings. [REDACTED], who co-signed the note by [REDACTED] requested an evaluation by a pain specialist as a result of this apparent discrepancy. Based on the ACOEM guidelines and criteria which recommend consultation for uncertain diagnoses and to aid in determining treatment and return to work fitness, as well as the clinical documentation stated above, the request is medically necessary.