

Case Number:	CM14-0048853		
Date Assigned:	06/25/2014	Date of Injury:	05/12/2007
Decision Date:	08/14/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	03/27/2014

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 injured worker is a 34 year-old female who was reportedly injured on May 12, 2007. The mechanism of injury is noted as a twisting injury to the low back. The most recent progress note dated October 10, 2013 indicates that there are ongoing complaints of low back pain, stress and irritability. The physical examination demonstrated fatigue and depression. Previous treatment includes injection therapy, IDET (Intradiscal Electrothermal Annuloplasty) procedure, physical therapy and multiple medications. Chronic pain protocol was also completed in combination with spinal cord stimulator. A request had been made for magnetic resonance imaging the lumbar spine had MS Contin and was not certified in the pre-authorization process on March 6, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 53,303. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: When noting the date of injury, the injury sustained, the treatment rendered, the multiple interventions there is no clinical indication of any worsening pathology or need for a repeat magnetic resonance image. The finding on physical examination are modest at best and there is no surgical lesion suggested. Based on the records presented for review medical necessity has not been established. Therefore, the request is not medically necessary.

60 MS Contin 60 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation ODG(The Official Disability Guideline), Low Back- Lumbar & Thoracic (Acute & Chronic)MS Contin.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page 74, 78, 93 of 127 Page(s): 74 78 93 OF 127.

Decision rationale: California Medical Treatment Utilization Schedule guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. When noting the physical examination findings and the minimal changes on imaging studies the standard is not met. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. One does not see significant pain relief or increased functionality with uses preparation. The injured worker suffers from chronic pain; however, there is no documentation of improvement in their pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not medically necessary.

180 Dilaudid 4mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydromorphone(Dilaudid).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page 74, 78, 93 of 127 Page(s): 74 78 93 OF 127.

Decision rationale: California Medical Treatment Utilization Schedule supports short-acting opiates for the short-term management of moderate to severe breakthrough pain. It is noted that the pain complaints are unending, however there is no specific pathology to support the complaints. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. One does not see any pain relief with the medication protocol outlined. The injured worker suffers from chronic pain; however, there is no clinical documentation of improvement in their pain or function with the current regimen. As such, the medical necessity is not been established. Therefore, the request is not medically necessary.

30 Ambien 5mg: Upheld

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

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

Decision rationale: The parameters outlined in the Official Disability Guidelines are used. This medication is indicated for short-term (usually 2-6 weeks) treatment of insomnia. Proper sleep hygiene is critical with chronic pain scenario. However, this is a short-term medication and not intended for chronic or indefinite use. The medical necessity for this preparation is not been established. Therefore, the request is not medically necessary.

(1) Walker with a seat: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines), Hip & Pelvis (Acute & Chronic) Assisted Devices for Ambulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 99 of 127 Page(s): 99 OF 127.

Decision rationale: When noting the mechanism of injury, the minimal changes on physical examination or objective studies, there is no clinical reason why an assisted device is necessary in this situation. If anything, increase ambulation, increase physical activity would support the rehabilitation of this individual and this device would achieve just the opposite. The medical necessity is not established. Therefore, the request is not medically necessary.