

Case Number:	CM14-0056985		
Date Assigned:	07/09/2014	Date of Injury:	11/13/2000
Decision Date:	09/26/2014	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/28/2014

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 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 injured worker is a 64 year old female with a reported date of injury on 11/13/2000. The mechanism of injury was not provided. The injured worker's diagnoses included lumbar degenerative disc disease with collapse and up-down foraminal stenosis, lumbar disc herniation at L5-S1, and bilateral lumbar radiculopathy, right more severe than left. The injured worker's past treatments included an intramuscular steroid injection. The injured worker's diagnostic testing included an EMG/NCV for which no results were provided, and an MRI which revealed L5-S1 stenosis. The injured worker's surgical history included bilateral L5-S1 foraminotomies. In a letter signed 08/19/2013 the clinician reported the injured worker complained that previous symptomology of radiculopathy had returned post bilateral L5-S1 foraminotomies. No weakness was seen on exam and no restrictions on current activities were noted. The injured worker was seen on 12/10/2013 and no complaints of pain or physical exam findings were provided. The injured worker was seen on 04/01/2014 for follow up of EMG and MRI. The notes reported that the injured worker did not have any pain at the time of visit. There were no documented physical exam findings other than vital signs and no review of the tests was documented. The injured worker's medications included venlafaxine ER 150 mg daily, ibuprofen 200 mg once daily, instaflex joint supplement, clonazepam 1 mg daily, trazodone 100 mg 2 at bedtime, Wellbutrin XL 300 mg daily, and Celebrex 200 mg daily. The request was for Pain management consult. No rationale for the request was provided. No request for authorization form was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management consult: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Chronic, Office Visits.

Decision rationale: The request for Pain management consult is not medically necessary. The injured worker had no documented complaints of pain in the most recent clinic notes provided. The Official Disability Guidelines state the need for a clinical office visit with health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The injured worker's medication list did not include opioids. The documentation did not provide an assessment of the injured worker's pain and functional condition. The requesting physician's rationale for the request is not indicated within the provided documentation. As there is a lack of documentation which demonstrates the injured worker's need for a pain management consult, the request would not be indicated. Therefore, the request for Pain management consult is not medically necessary.