

<b>Case Number:</b>	CM14-0206220		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	10/23/2008
<b>Decision Date:</b>	02/17/2015	<b>UR Denial Date:</b>	11/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2014

### 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 Occupational 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic neck and low back pain reportedly associated with an industrial injury of October 20, 2008. In a Utilization Review Report dated November 27, 2014, the claims administrator retrospectively denied office visits which transpired between March 25, 2014 and August 28, 2014. The claims administrator referenced non-MTUS ODG Guidelines in conjunction with Chapter 8 and Chapter 12 ACOEM guidelines in its determination. The applicant had undergone earlier carpal tunnel release surgeries, left and right, and left and right middle finger release surgeries. The applicant, per the claims administrator, was reportedly using Flexor, Norco, Zestril, metformin, oxycodone, Prilosec, Soma, tramadol, and Tylenol with Codeine per an October 7, 2013, progress note. The claims administrator stated that the applicant had undergone a cervical MRI of March 25, 2014, and a progress note of April 29, 2014. The claims administrator suggested that the attending provider should request authorization for office visits based on preceding office visits. The claims administrator suggested that the request is imprecise. The applicant's attorney subsequently appealed. On January 2, 2015, the applicant reported ongoing complaints of neck and back pain status post earlier cervical fusion surgery on April 29, 2014. The applicant had undergone lumbar radiofrequency ablation procedure on June 30, 2014. The applicant reportedly was using Percocet, Soma and Valium, several of which were refilled. The applicant's problem list included cervical radiculitis, lumbar radiculitis, thoracic spine pain, chronic pain syndrome, insomnia, hypertension, restless legs syndrome, major depressive disorder, generalized anxiety disorder, dyslipidemia and diabetes mellitus. The applicant was overweight, with a BMI of 29. The applicant's work status was not clearly outlined on this occasion. On March 17, 2014, the applicant again reported multifocal pain complaints. Cervical MRI imaging was endorsed. The

applicant had reportedly failed physical therapy and stated that her neck and back pain had worsened over the preceding year. The applicant was overweight, with a BMI of 30. The applicant's work status was not clearly stated, although it did not appear that the applicant was working. The applicant's medications included Lipitor, brimonidine eye drops, Soma, timolol eyedrops, Norco, latanoprost eyedrops, Zestoretic, metformin, Prilosec and prednisolone eyedrops. The applicant was still smoking every day. On November 25, 2014, the applicant reported ongoing issues with depression. The applicant stated that she missed her children, many of whom lived elsewhere. Zoloft had reportedly ameliorated her issues with depression. The applicant stated that she had been abused by both a supervisor and family members in the past.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Retrospective office visits (DOS: 3.25.14 - 8.28.14):** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chapter : Neck & Upper Back ; Low Back - Lumbar & Thoracic

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

**Decision rationale:** As noted in the MTUS Guidelines in ACOEM Chapter 5, page 79, frequent office visits are "often warranted" for monitoring purposes in order to provide structure and reassurance even in applicants whose conditions are not expected to change appreciably from week to week. Here, the applicant had ongoing issues with chronic pain syndrome, depression, generalized anxiety disorder, etc., evident during the time-frame in question. The applicant had undergone cervical fusion surgery during the time-frame under review. The applicant was on a variety of opioid and non-opioid agents. Frequent follow-up visits, thus, were indicated here for various purposes, including medication monitoring purposes. Therefore, the request is medically necessary.