

<b>Case Number:</b>	CM15-0183904		
<b>Date Assigned:</b>	10/02/2015	<b>Date of Injury:</b>	11/12/1996
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 41 year old male, who sustained an industrial injury on 11-12-1996. He has reported injury to the nose, neck, chest, and low back. The diagnoses have included cervical pain; low back pain; lumbar disc disorder; chronic pain syndrome; history of nasal dorsal and septal fracture; nasal airway obstruction; turbinate hypertrophy; nasal vestibular stenosis; and left septal deviation. Treatment to date has included medications, diagnostics, home exercise program, and surgical intervention. Medications have included Morphine Sulfate Extended-Release. Surgical intervention has included open reduction and internal fixation of nasal dorsal and septal fracture, bilateral submucous reduction of the inferior turbinate, ear cartilage grafting to nasal tip grafting, and repair of the vestibular stenosis, on 08-05-2015. A progress note from the treating physician, dated 08-26-2015, documented a follow-up visit with the injured worker. The injured worker reported neck pain, upper back pain, low back pain, and left knee pain, which he describes as shooting; the pain level has remained unchanged since the last visit; the pain is rated at 5 out of 10 in intensity; he also complains of fatigue, dryness of the eyes, joint pain, and muscle aches; he is not trying any other therapies for pain; he reports no change in activities of daily living; he is working; he is taking his medications as prescribed and they are working well; he reports 50-70% pain reduction with his pain medication; and he has continued functional benefit with his pain medications. Objective findings included he is no acute distress; gait is normal; lumbar spine reveals decreased lumbar lordosis without scoliosis; he has a well-healed incision on the right thoracic area from chest tubes and a thoracotomy scar on the right side of his thoracic spine; tenderness is noted over the lumbar paraspinal muscles; motor testing is limited by pain; and he has no nasal obstruction at this point. The treatment plan has included the request for referral to a provider for nasal obstruction. The original utilization review, dated 09-18-2015, non-certified the request for referral to a provider for nasal obstruction.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Referral to [REDACTED] for nasal obstruction:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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, p127.

**Decision rationale:** The claimant has a remote history of a work injury occurring in November 1996 with multiple traumatic injuries including a nasal fracture. He underwent nasal surgery in 1999 and 2002. He has constant congestion with recurrent episodes of epistaxis and awakening with a dry mouth. When seen, he was having difficulty breathing through his nose. He had ongoing mid and low back pain. He was continuing to work. Physical examination findings included ambulating without an assistive device. There was cervical, lumbar, and bilateral trapezius muscle tenderness. Authorization was requested for a consultation to address the claimant's nasal obstruction. Guidelines recommend consideration of a consultation if clarification of the situation is necessary. In this case, the claimant has a history of nasal trauma with two prior surgeries and continued obstruction causing recurrent epistaxis and appearing to interfere with breathing at night. Requesting a consultation for further evaluation is medically necessary.