

Case Number:	CM15-0197659		
Date Assigned:	10/13/2015	Date of Injury:	08/11/2010
Decision Date:	11/20/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	10/07/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 32 year old male who sustained an industrial injury on 08-11-2010. A review of the medical records indicated that the injured worker is undergoing treatment for lumbosacral disc degeneration, congenital spinal stenosis and depressive disorder. According to the treating physician's progress report on 09-04-2015, the injured worker continues to experience low back pain radiating to the bilateral lower extremities rated at 8 out of 10 on the pain scale. On 08-18-2015, a progress report noted no relief from the recent lumbar epidural steroid injection and pain level remains at 8 out of 10. Some of the objective findings submitted with the review are difficult to decipher. Examination demonstrated tenderness to palpation at L3 through L5 and decreased sensation from L5 to S1. There was a positive straight leg raise at 50 degrees. Flexion was decreased to 55 degrees. Prior treatments have included diagnostic testing, physical therapy, cortisone injections, lumbar epidural steroid injection (no date documented), transcutaneous electrical nerve stimulation (TENS) unit, psychiatric AME (no date documented) and medications. Current medications were listed as Ibuprofen and Gabapentin. Treatment plan consisted of pain management follow-up and the current request for follow-up with [REDACTED]. On 09-08-2015, the Utilization Review determined the request for follow-up with [REDACTED] was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow Up: 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 Official Disability Guidelines (ODG) medical reevaluation.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ODG, states follow up medical visits are based on medical necessity and the patient's progress, symptoms and ongoing complaints. The patient does have ongoing complaints and symptoms associated with the back pain and depression. Therefore, a medical follow up visit would be medically necessary.