

Case Number:	CM15-0055094		
Date Assigned:	03/30/2015	Date of Injury:	10/03/2005
Decision Date:	05/06/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	03/23/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 39 year old male, who sustained an industrial injury on 10/03/2005. According to the only progress report submitted for review and dated 01/13/2015, the injured worker complained of neck pain that radiated down the bilateral upper extremities and to the hands, low back pain that radiated down the bilateral lower extremities and to the feet, upper extremity pain in the bilateral hands and shoulders, groin pain and gastroesophageal reflux disease related medicated associated gastrointestinal upset. Diagnoses included lumbar disc degeneration, lumbar radiculopathy, anxiety, depression, diabetes mellitus, gastroesophageal reflux disorder, hypertension, morbid obesity, medication related dyspepsia, status post bilateral shoulder arthroscopy status post left femoral open reduction internal fixation (separate claim). The injured worker received a Toradol/B12 injection. Specific medications tried and failed in the past included Butrans patch, Clonidine, Fentanyl patch, Gabapentin and Lyrica. Treatment recommendations included continue ongoing home exercise program and medications. Diovan and Zofran were discontinued. Medications regimen included Ketoprofen, Omeprazole and Suboxone. A request for authorization dated 03/12/2015 was submitted for review. The services requested included hearing tests to be performed on 04/16/2015. An Otolaryngology Qualified Medical Examination was scheduled for 04/16/2015 also.

IMR ISSUES, DECISIONS AND RATIONALES

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

Audiography: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines History and Physical Assessment Page(s): 5-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Section, Audiometry.

Decision rationale: Pursuant to the Official Disability Guidelines, audiography is not medically necessary. Audiometry is recommended following brain injury or occupational hearing loss is suspected. Audiometry is generally accepted in well established. See the guidelines for additional details. In this case, the injured worker's working diagnoses are lumbar disc degeneration; lumbar radiculopathy; anxiety; Depression; diabetes mellitus; gastroesophageal reflux; hypertension; morbid obesity; medication related dyspepsia; status post bilateral shoulder arthroscopy; status post left femoral open reduction internal fixation separate claim. The date of injury is October 3, 2005. The mechanism of injury is contained not the medical record. The medical record contains 31 pages. There is a single progress note from a pain management specialist dated January 13, 2015. There is no reference to hear loss or related hearing complaints. There are no diagnoses related to hearing complaints. Although audiometry is recommended in certain circumstances, there is no documentation in the medical record to support hearing loss. There is no documentation in the medical record indicating audiometry is medically necessary. Consequently, absent clinical documentation with subjective and objective complaints referencing hearing loss, audiography is not medically necessary.

Tympanometry: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines History and Physical Assessment Page(s): 5-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Section, Audiometry.

Decision rationale: Pursuant to the Official Disability Guidelines, tympanometry is not medically necessary. Audiometry is recommended following brain injury or occupational hearing loss is suspected. Audiometry is generally accepted in well-established. See the guidelines for additional details. Thorough history taking is there always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic

studies should be ordered in this context and not simply for screening purposes. In this case, the injured worker's working diagnoses are lumbar disc degeneration; lumbar radiculopathy; anxiety; depression; diabetes mellitus; gastroesophageal reflux; hypertension; morbid obesity; medication related dyspepsia; status post bilateral shoulder arthroscopy; status post left femoral open reduction internal fixation separate claim. The date of injury is October 3, 2005. The mechanism of injury is contained not the medical record. The medical record contains 31 pages. There is a single progress note from a pain management specialist dated January 13, 2015. There is no reference to hear loss or related hearing complaints. There are no diagnoses related to hearing complaints. Although audiometry is recommended in certain circumstances, there is no documentation in the medical record to support hearing loss. There is no documentation in the medical record indicating tympanometry is medically necessary. Consequently, absent clinical documentation with subjective and objective complaints referencing hearing loss, tympanometry is not medically necessary.