

Case Number:	CM13-0009217		
Date Assigned:	09/11/2013	Date of Injury:	10/01/1991
Decision Date:	01/24/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	08/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Medicine, and is licensed to practice in Oklahoma, Texas. 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 physician 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 patient is a 57-year-old female who reported an injury on 10/01/1991. The patient is noted to have low back pain radiating to the lower extremities, neck pain radiating into the bilateral upper extremities, and headaches. The patient is noted to have 8/10 pain with medications and 10/10 pain without medications. The patient has exam findings of L4 through S1 vertebral tenderness, lumbar paraspinous muscle spasm, decreased cervical spine range of motion, C4 through C7 vertebral tenderness, cervical paraspinous muscle spasm, and decreased right shoulder motion. The patient is noted to be utilizing a wheelchair for mobility and has an intrathecal pain pump in place. The patient is noted to have undergone prior lumbar fusion surgery and has current diagnoses consistent of radiculopathy, depression, anxiety, and chronic pain. Notes indicate that the patient required further psychological treatment and that the patient's provider stopped providing psychiatric medications as he had not seen the patient since 09/2012. Notes indicate that the patient's mobility is severely limited and she is dependent upon a wheelchair. The patient's vehicle is noted to not be equipped for transportation with a wheelchair.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for 1 Orthopedic visit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The patient has been recommended for orthopedic office visit; however, the clinical notes submitted for review do not provide sufficient rationale for why the patient would need to see an orthopedist. The patient's physical exam findings included tenderness and spasms. However, there are no significant red flags to support the need to see an orthopedic provider at this time. As such, the request remains non-certified.

The request for 1 Psychiatric visit: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Psychological evaluations Page(s): 100-101.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines recommends psychological evaluations to assess for diagnoses and interventions. The notes submitted for review indicate that the patient has not been seen by her psychiatrist since 09/2012. Therefore, the provider has refused to refill medications. The patient does have diagnoses of depression and anxiety. The patient would benefit from psychiatric visit at this time to refill medications and assess for other treatment options. As such, the request is certified.

The request for 1 Follow-up Comprehensive metabolic panel (CMP) lab result: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MedlinePlus, Comprehensive metabolic panel

Decision rationale: The documentation submitted for review indicates that the patient's medications include intrathecal pain pump, Dilaudid, tizanidine, Ondansetron, and vitamin D. The documentation submitted for review did not provide a sufficient rationale to support the need for a comprehensive metabolic panel. It is unclear as to the patient's last CMP, if any, and results. The patient has undergone urine drug screen and has no significant change in medication regimen. Therefore, the request for CMP lab is non-certified at this time.

The request for 30 Ondansetron 4mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition do not address Ondansetron.

Decision rationale: The documentation submitted for review indicates the patient is being recommended for Ondansetron for nausea. However, guidelines state that Ondansetron is recommended for nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery. There is no indication the patient has undergone recent surgery or is undergoing treatment for cancer. Furthermore, there is lack of documentation of subjective complaints of nausea or vomiting to warrant this medication. As such, the request is non-certified at this time.

The request for 90 Tizanidine HCL 4mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Tizanidine Page(s): 66.

Decision rationale: California Chronic Pain Medical Treatment Guidelines recommend short-term use of muscle relaxers including tizanidine. The documentation submitted for review indicates the patient has been utilizing this medication long-term. Therefore, continuation would not be supported at this time. Given the above, the request is non-certified

The request for 135 Dilaudid 2mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

Decision rationale: California Chronic Pain Medical Treatment Guidelines recommend documentation of the 4 A's prior to ongoing management of opioids. The documentation submitted for review fails to reveal any significant change in the patient's pain to warrant ongoing use of Dilaudid at this time. Notes indicate that the patient's pain was reduced by 20% with medication regimen including intrathecal pain pump. Therefore, there is lack of documentation of the 4 A's at this time. As such, the request is non-certified.

The request for Transportation to and from doctor visits: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Transportation

Decision rationale: Guidelines recommend transportation for patients with disabilities preventing them from self-transport. The documentation indicates the patient has pain complaints; however, there is any significant functional deficits to demonstrate why the patient would be wheelchair bound and/or require transportation. As such, the request is non-certified.