

<b>Case Number:</b>	CM14-0004908		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	08/14/1998
<b>Decision Date:</b>	06/09/2014	<b>UR Denial Date:</b>	01/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in 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 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 injured worker is a 69 year old female who reported an injury on 08/14/1998 secondary to a fall. The clinical note dated 07/31/2013 reported that the injured worker complained of inability to function and pain rated 8/10 without medications. The injured worker reportedly stated she was able to walk ½ mile and her pain was rated at a 4-5/10 with medication. The physical examination reported the injured worker had functional range of motion at 90 degree flexion and 5 degrees extension and she was tender to palpation of the lumbar spinous processes. The diagnoses included lumbar back pain and myalgia and myositis. The treatment included continuation of Fentanyl and Skelaxin. The request for authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PAIN MANAGEMENT REFERRAL QTY: 1.00:** Overturned

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

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

**Decision rationale:** The request for Pain Management referral QTY: 1.00 is certified. According to the Official Disability Guidelines, the need for a clinical office visits should be individualized based upon a review of the patient concerns, signs and symptoms, and clinical findings. Additionally, the determination should be based on what medications the patient is taking, as some medicines such as opiates, or certain antibiotics, require close monitoring. Based on the clinical information provided for review, the injured worker has chronic low back pain, specified as severe pain without use of medications, moderate pain with use of medications, inability to function, and is being treated with multiple medications including opioids. Therefore, a referral to a pain management specialist to assess effectiveness of her medications and evaluate for further treatment options to decrease pain and increase function is reasonable. Therefore, the request for Pain Management referral QTY: 1.00 is medically necessary.