

Case Number:	CM14-0131187		
Date Assigned:	08/20/2014	Date of Injury:	07/09/2012
Decision Date:	09/29/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/17/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 52-year-old female who reported injury on 07/09/2010 caused by an unspecified mechanism. The injured worker's treatment history included, H wave unit, physical therapy, aquatic sessions, and medications. The injured worker was evaluated on 07/03/2014. The injured worker complained of lower back and right knee pain with radiation to the right leg. The provider noted the injured worker stated her symptoms were improving; however, she recently started feeling worse. The injured worker uses a knee brace, as she feels anxious of falling with walking due to leg weakness. The injured worker's pain was rated at 7/10 with medications and 8/10 without medications. She described the pain as cramping, shooting, electric like and burning with muscle pain and pins and needles sensation. The pain was aggravated by bending forward, bending backwards, kneeling, stooping, doing exercises, pushing, shopping cart) leaning forward, and prolonged standing. The pain was alleviated with rest, medication, heat, and lying down and relaxing. The physical examination of the cervical spine revealed range of motion was full in all planes of the cervical spine. There was no spinous process tenderness or masses palpable along the cervical spine. Physical examination of the lumbar spine revealed range of motion to forward flexion was 20 degrees, extension was 10 degrees, and side bending was 5 degrees. Rotation was limited. There was normal alignment with mild loss of lumbar lordosis. There is tenderness to palpation over the right lumbar paraspinal muscles consistent with spasm. There was sciatic notch tenderness, gluteal spasm, and palpation over the right lumbar paraspinal muscle consistent with spasms. And piriformis spasm. There was increased pain with piriformis stretching. There was a positive lumbar facet loading maneuver. There was a positive straight leg raise test on the right in the seated and supine position. There was sacroiliac joint tenderness on the right with positive Patrick's test. Atrophy

was noted in the right quadriceps and hamstring muscles. Motor strength was 5/5 throughout the bilateral upper extremities, except 4+/5 on bilateral shoulder flexion/abduction. Motor strength was 5/5 throughout the bilateral lower extremities, except 4+/5 on the left hip flexion and left knee extension, 4/5 on the right knee extension, right ankle dorsiflexion, and right ankle plantar flexion, and 3/5 on the right hip flexion. Diagnoses include displacement of lumbar intervertebral disc without myelopathy, lumbosacral spondylosis without myelopathy, and lumbago. Medications included Ultram ER, Flexeril, diclofenac, Prilosec, trazodone, and Norco. The Request for Authorization and rationale were not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management Specialist Evaluation: Upheld

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) Office Visits.

Decision rationale: The request for pain management specialist evaluation is not medically necessary. Per the Official Disability Guidelines (ODG), office visits are recommended based on patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The documents submitted indicated the injured worker was improving however, had a recent relapse. Additionally, the provider did not indicate any failed pain medication for the injured worker. Given the above, the request for consultation pain management specialist is not medically necessary.