

Case Number:	CM14-0160053		
Date Assigned:	10/03/2014	Date of Injury:	02/20/2007
Decision Date:	11/06/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	09/29/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas & 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 48-year-old male who reported an injury on 02/20/2007, due to an unknown mechanism. Diagnoses were degeneration of lumbar disc, chronic pain syndrome, low back pain, pelvic/hip pain, intervertebral disc disorder without myelopathy, plantar fasciitis; cervicgia; spasm of muscle; and cervical radiculopathy. Physical examination dated 08/26/2014 revealed complaints of right arm/shoulder with pain that radiated into the neck and low back pain that radiated into both legs. The injured worker used a crutch for stability. It was reported that the injured worker had tried and failed a trial of a spinal cord stimulator. The injured worker rated the pain a 6/10 on the VAS score scale. The injured worker reported no change in pain since last office visit. The injured worker reported the pain was being controlled with oxycodone 20 mg, which worked within 30 to 40 minutes, and gave him a 40% to 60% relief that lasted 2 to 3 hours. The injured worker reported no adverse side effects from their medication. The injured worker was going to meetings with psych, cognitive behavioral therapy, and was gaining different insights into pain perception and outward display to others when coping with his pain. Examination of the cervical spine revealed decreased range of motion with painful forward flexion, extension, right and left twist. Examination of the lumbar spine revealed decreased range of motion with painful forward flexion, extension, right and left twist. Medications were methadone, oxycodone, and trazodone. Treatment plan was for a lumbar traction unit, referral to sleep medicine, x-ray of the left shoulder, and methadone. The rationale and 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:

Lumbar traction unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back -Lumbar & Thoracic (Acute & Chronic)

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, Traction

Decision rationale: The decision for lumbar traction unit is not medically necessary. The Official Disability Guidelines state that traction is not recommended using power traction devices, but home based patient controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain. The rationale for requesting a lumbar traction unit was not reported. It was not reported that this was to be a home based patient controlled gravity traction unit, and to be used in adjunct to another functional restoration program. The clinical information submitted for review does not justify the decision for a lumbar traction unit. Therefore, the request is not medically necessary.

Referral to sleep medicine: 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6, page 163

Decision rationale: The decision for referral for sleep medicine is not medically necessary. The American College of Occupational and Environmental Medicine Guidelines state that a consultation is intended to aide in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work. There was no clear rationale to support the consultation. Therefore, this request is not medically necessary.

X-ray of the left shoulder (2 views): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The California Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red flag conditions are ruled out. These are the few exceptions: stress films of the AC joints (views of both shoulders with or without patient holding 15 pound weights), may be indicated if the clinical diagnosis is AC joint separation. Care should be taken when selecting this test because the disorder is usually clinically obvious, and the test is painful and expensive relative to its yield. If an initial or recurrent shoulder dislocation presents in the dislocated position, shoulder films before and after reduction are indicated. Persistent shoulder pain, associated with neurovascular compression symptoms (particularly with abduction and external rotation), may indicate the need for an AP cervical spine radiograph to identify a cervical rib. Routine testing (laboratory tests, plain film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to 6 weeks of activity limitation due to shoulder symptoms, except where a red flag is noted on history or examination raises suspicion of a serious shoulder condition or referred pain. The injured worker did not have an emergence of a red flag upon physical examination. The rationale was not reported for why there was a need for an x-ray of the left shoulder. The clinical information submitted for review does not provide evidence to justify x-ray of the left shoulder (2 views). This request is not medically necessary.

Methadone 10mg #240: Upheld

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

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

Decision rationale: The decision for methadone 10 mg, quantity 240, is not medically necessary. The Official Disability Guidelines have set up steps for prescribing methadone. The drugs should be used with caution in opioid naive patients due to the risk of life threatening hypoventilation. Inform the patient that they should not be tempted to take more methadone than prescribed due to the dangerous buildup that can lead to death. The patient should be warned not to use alcohol, benzodiazepines, or other CNS depressants. Inform the patient of the potential adverse side effects of methadone. Although the injured worker has reported pain relief and functional improvement from the medication, the provider did not indicate a frequency for the medication. Therefore, this request is not medically necessary.