

<b>Case Number:</b>	CM14-0093762		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	03/13/2001
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 Nevada. 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 records presented for review indicate that this 56-year-old individual was reportedly injured on March 13, 2001. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated April 2, 2014 indicates that there are ongoing complaints of neck and back pain. The pain is noted to be constant, radiating into the bilateral upper extremities, and no relief is reported. The physical examination demonstrated a 5', 118 pound individual who has a normal motor examination in both the upper and lower extremities, a decreased sensory testing in the C5, C6 & C7 dermatomes as well as the L4, L5 and S1 dermatomes. Diagnostic imaging studies were not presented. Previous treatment includes cervical spine surgery, lumbar spine surgery, multiple medications and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on June 3, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Psychiatric Consult:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Stress related conditions. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**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 7, page 127.

**Decision rationale:** As noted in the progress note dated April 2, 2014 the injured worker has undergone a psychiatric evaluation. Therefore, when noting the parameters and suggestions offered and that consultation, there is no clinical indication to pursue an additional psychiatric consultation. The request for Psychiatric Consult is not medically necessary and appropriate.

**Pain Management Consult:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG) Pain Chapter.

**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 7, page 127.

**Decision rationale:** As noted in the progress note dated April 2, 2014 the injured worker has a long history of chronic pain problems. Given the treatment rendered, there is no clinical indication presented for additional independent consultation. Therefore, this request is not medically necessary.

**Home Help 8 hrs a day/ 7 days a week:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51 of 127.

**Decision rationale:** When noting the date of injury, the injury sustained, the cervical spine surgery completed the ongoing complaints of pain, tempered by the physical examination offered and noting a slight sensory loss there is no clinical indication presented for the need of a home health aide. The surgical site is well healed, and there is a normal motor function assessment reported. As outlined in the MTUS, home health care does not include homemaker services like shopping, cleaning and laundry and personal care. As such, there is no data presented to suggest the medical necessity for additional home health services. Therefore the request for Home Help 8 hrs a day/ 7 days a week is not medically necessary and appropriate.

**Transportation to and from Visits:** 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) pain chapter updated July, 2014.

**Decision rationale:** The MTUS and ACOEM guidelines are silent on this topic. The parameters noted in the ODG are applied. The physical examination does not offer any indication why this individual cannot participate in public transportation or operate a motor vehicle. As such, there is no medical necessity established for the need for such transportation services. Therefore the request for Transportation to and from Visits is not medically necessary and appropriate.

**Lyrica 75 mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19,99 of 127.

**Decision rationale:** As outlined in the MTUS, this medication has been documented to be effective in the treatment of diabetic neuropathy and post-herpetic neuralgia. An off label use of this treatment is for neuropathic pain lesion. However, based on the physical examination reported there has been no change in the overall clinical situation. The findings of physical examination noted a normal motor examination and some sensory losses. Given that there is no noted efficacy or utility with the continued use of this preparation the medical necessity for the additional use has not been established therefore the request for Lyrica 75 mg #60 is not medically necessary and appropriate.

**Tramadol ER 150 mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82,113 of 127.

**Decision rationale:** As noted in the MTUS, the use of this medication has been supported after there has been evidence of other medications that have not been effective. However, based on the progress notes presented there is no noted increase in functionality, decrease in symptomology, or any other objective indicator that this medication is having any of its intended effect. Therefore, based on the limited clinical information presented in the progress notes reviewed there is insufficient data presented to establish a medical necessity for the ongoing uses medication. Therefore, this request is not medically necessary.

**Cartivisc 500-200-150 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine. Decision based on Non-MTUS Citation ODG-Pain Chapter-Glucosamine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50 of 127.

**Decision rationale:** As outlined in the MTUS, this medication is recommended as an option given the findings noted with the wrist. However, when noting the injury sustained, the ongoing complaints, the lack of any change in physical examination there is no data presented to suggest that this medication is having any efficacy or utility in terms of achieving its intended goal. Therefore, the request for Cartivisc 500-200-150 mg #90 is not medically necessary and appropriate.

**Orthopedic re-evaluation:** 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) Pain Chapter- Evaluation & Management.

**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 7, Page 127.

**Decision rationale:** As outlined in the ACOEM guidelines, when the diagnosis is uncertain or extremely complex it states that appropriate consultations would be indicated. However, when noting the date of injury, the straightforward appearance relative to the physical examination, there is no data presented to suggest that an additional orthopedic consultation will be necessary. This would not alter the diagnostic change the treatment plan as each has been well-established in the years subsequent to the date of injury. Therefore, based on the progress notes reviewed the request for Orthopedic re-evaluation is not medically necessary and appropriate.