

Case Number:	CM15-0012321		
Date Assigned:	01/29/2015	Date of Injury:	12/04/2013
Decision Date:	03/27/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/21/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 39 year old male sustained a work related injury on 12/04/2013. According to an illegible handwritten progress report dated 06/10/2014, diagnoses included myofasciitis, anxiety, headaches, insomnia, sexual dysfunction, rotator cuff, and radiculitis cervical and lumbar, pain in left shoulder, right knee, left elbow and right ankle/foot. Treatment plan included acupuncture. According to a Neuropsychology Examination dated 12/16/2014, the injured worker complained of lower back pain described as needles in the lower back region radiating to his med back and back of both of his legs. The injured worker also complained of headaches, right knee pain, left shoulder pain and left elbow pain. Treatments have included pain patches, a TENS unit, massage, rest, ice baths and topical cream, medications and physical therapy. On 12/31/2014, Utilization Review non-certified Retro Office Evaluation quantity 1, Retro Range of Motion quantity 1, Retro Office Evaluation quantity 1 and Retro Drug Screen quantity 1. According to the Utilization Review physician, there was lack of documentation to support the request. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 5/5/2014) Office Evaluation #1: Overturned

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 ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch:7 page 127

Decision rationale: The 05/08/14 report by [REDACTED] states he reviewed the 05/05/14 Pain management consultation report by [REDACTED] [REDACTED] further states the patient was referred to [REDACTED] and the patient was provided a trial of medications by [REDACTED] who also collected a baseline urine toxicology screen, and initiated a pain contract. [REDACTED] referred the patient for orthopedic evaluation of the right knee. The 05/05/14 report by [REDACTED] is not included for review. In this case, the patient is documented with multiple complex injuries and is prescribed medications that include Ultracet, Naprosyn, Flexeril and topical creams. The ACOEM Guidelines support referral to the expertise of other specialists when it may help the physician provide an appropriate course of care. The request IS medically necessary.

Retro (DOS 05/05/2014) Range of Motion #1: 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 low back chapter regarding range of motion

Decision rationale: The reports provided for review show the patient presents with cervical and lumbar pain, pain in left shoulder, right knee, left elbow and right ankle/foot. The current request is for RETRO DOS 05/05/14 RANGE OF MOTION #1. The RFA is not included. The reports do not state if the patient was working. The ACOEM, MTUS, and ODG Guidelines do not specifically discuss range of motion or strength test. However, ODG Guidelines under the low back chapter regarding range of motion does discuss flexibility. The ODG Guidelines has the following, "Not recommended as the primary criteria, but should be part of a routine musculoskeletal evaluation." The only treatment report provided dated 05/05/14 is for work conditioning/physical therapy that states the patient has lumbar range of motion complaints due to pain. ODG Guidelines considers examination such as range of motion part of a routine musculoskeletal evaluation, and the treating physician does not explain why a range of motion test is requested as a separate criteria. It should be part of an examination performed during office visitation. Furthermore, the 05/05/14 evaluation is not provided for review. The requested range of motion IS NOT medically necessary.

Retro (DOS 05/23/2014) Office Evaluation#1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 341.

Decision rationale: The reports provided for review show the patient presents with cervical and lumbar pain, pain in left shoulder, right knee, left elbow and right ankle/foot. The current request is for RETRO DOS 5/23/14 OFFICE EVALUATION #1. The RFA is not included. The reports do not state if the patient was working. The ACOEM Guidelines page 341 supports orthopedic follow-up evaluations every 3 to 5 days whether in-person or telephone. In this case, the 05/23/14 report is not included for review in order to evaluate this request. Lacking clear documentation, the request IS NOT medically necessary.

Retro (DOS 05/23/2014) Drug Screen #1: 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 Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Urine drug testing

Decision rationale: The reports provided for review show the patient presents with cervical and lumbar pain, pain in left shoulder, right knee, left elbow and right ankle/foot. The current request is for RETRO DOS 5/23/14 DRUG SCREEN #1. The RFA is not included. The reports do not state if the patient was working. While MTUS Guidelines do not specifically address how frequently UDS should be obtained for various risks of opiate users, ODG Guidelines provide clearer recommendation. It recommends once yearly urine screen following initial screening with the first 6 months for management of chronic opiate use in low risk patient. ODG states, "Frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument." The report for DOS 05/23/14 is not included for review. As of 05/08/14 Ultracet, an opioid is documented to be prescribed for this patient. The 12/04/13 report shows use of opioids: Hydrocodone and Tramadol. The 05/08/14 report states a urinalysis sample was collected on 05/03/14. It is unclear why an additional test is needed for DOS 05/23/14. Once yearly testing is recommended following initial screening for low risk patients. There is no documentation that this patient is a moderate or high risk patient which would allow additional UDS testing. The request IS NOT medically necessary.