

Case Number:	CM15-0118960		
Date Assigned:	09/14/2015	Date of Injury:	12/11/2006
Decision Date:	11/04/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/19/2015

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: Arizona, Texas
 Certification(s)/Specialty: Internal Medicine

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 53 year old male, who sustained an industrial injury on December 11, 2006. The injured worker was evaluated on May 12, 2015. He reported that a dental consult was completed for rapid tooth decay and multiple tooth fractures. He had fractured a left front upper incisor and a lower molar. The evaluating physician noted that 'the dental loss and the appearance of his broken teeth is really demoralizing for the patient and an embarrassment to him if he has to encounter others. This is making his depression worse. He has had more problems with his low back and reported sensory changes in the left leg when he lies down. On physical examination, many 'if not all' of his teeth had visible fractures. His left upper front incisor was missing with only a small portion of the tooth being seen at the gum line. His gait and station were wide-based and antalgic and he used a cane for assistance. His muscle tone was increased and strength testing showed proximal weakness in the legs at 4-5 and distal weakness at 5-5. The injured worker was diagnosed as having traumatic brain injury secondary to organic brain syndrome, hydrocephalus with shunt, elevated prolactin, dental loss from effects of hypogonadism and chronic opiate use, rule out osteoporosis from opiate use, multiple leg fractures, pelvis fracture, recurrent left hip and bilateral ankle pain, and status post multiple reconstructive procedures of the left leg and pelvis. Treatment to date has included medications. His medications included Protonix 40 mg bid, Relpax 40 mg prn, Cymbalta 60 mg a day, Norco 1-2 four times per day, Zofran as needed, Sucralfate 1 gm four times per day, Lactulose 1 Tbsp four times per day, Reglan 5 mg four times per day, Xanax 0.5 mg as needed, Docusate as needed, Aspirin 81 mg a day, Pravastatin 20 mg a day, Rozarem 8.6 mg a day, Metaxalone

800mg three times per day, B-12 5000 mcg a day, Folate 5mg a day, Vitamin D 2000 units a day, and Methadone 15 mg four times per day. A request for authorization for In-home care, dental treatment and MRI of the lumbosacral spine was received on June 3, 2015. On June 9, 2015, the Utilization Review physician determined MRI of the lumbosacral spine, In-home care, and dental treatment were not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI LSS: 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).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: According to the ACOEM criteria for ordering an MRI for cervical or lumbar pain is emergence of a red flag (suspicion of a tumor, infection, fracture or dislocation), physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, clarification of the anatomy prior to an invasive procedure. When the neurologic exam is not definitive further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Such information can be obtained by an EMG or NCS. In this case the primary treating physician does not document a neurological exam consistent with significant dysfunction that would indicate a red flag. There is no surgical intervention planned and the injured worker is not participating in a strengthening program. An MRI of the lumbar spine is not medically necessary.

In-home care: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: According to the MTUS regarding home health services, recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. In this case the patient has a history of TBI and chronic pain, the documentation submitted doesn't support that he is home bound. The specific goals for home health are not clear. The medical necessity for home health services is not made.

Dental Treatment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation.

Decision rationale: A focused medical history, work history, and physical examination generally are sufficient to assess the patient who complains of an apparently job-related disorder. The initial medical history and examination will include evaluation for serious underlying conditions, including sources of referred symptoms in other parts of the body. The initial assessment should characterize the frequency, intensity, and duration in this and other equivalent circumstances. In this assessment, certain patient responses and findings raise the suspicion of serious underlying medical conditions. These are referred to as red flags. Their absence rules out the need for special studies, immediate consultation, referral, or inpatient care during the first 4 weeks of care (not necessarily the first 4 weeks of the worker's condition), when spontaneous recovery is expected, as long as associated workplace factors are mitigated. In some cases a more complete medical history and physical examination may be indicated if the mechanism or nature of the complaint is unclear. Records reviewed indicate that a dental consult was completed for rapid tooth decay and multiple tooth fractures. He had fractured a left front upper incisor and a lower molar. The evaluating physician noted that 'the dental loss and the appearance of his broken teeth is really demoralizing for the patient and an embarrassment to him if he has to encounter others. This is making his depression worse.' Treating doctor is recommending 'Dental Treatment'. However the requesting doctor is recommending a non-specific treatment plan in this case to treat teeth. Patient does seem to need dental care; however it is unclear to this reviewer on what kind of specific dental treatment this dentist is recommending. Absent further detailed documentation and clear rationale for a specific dental treatment plan, the medical necessity for this request is not evident. Per medical reference mentioned above 'a focused medical history, work history and physical examination generally are sufficient to assess the patient who complains of an apparently job related disorder' in order to evaluate a patient's needs. This reviewer does not believe this has been sufficiently documented in this case. This reviewer recommends non-certification at this time.