MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/30/2013

IMR Case Number:	CM13-0018557	**Date of Injury:**	12/11/2001
Claims Number:	[redacted]	**UR Denial Date:**	07/31/2013
Priority:	STANDARD	**Application Received:**	08/29/2013
Employee Name:	[redacted]		
Provider Name:	[redacted] M.D		
Treatment(s) in Dispute Listed on IMR Application:			
MULTIPLE SERVICES			

DEAR [redacted]

MAXIMUS Federal Services has completed the Independent Medical Review ("IMR") of the above workers' compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [redacted]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Pulmonary Diseases and is licensed to practice in California. 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

CLINICAL CASE SUMMARY

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

The patient is a 44-year-old male with a date of injury 12/11/2001 which resulted in diagnoses of lumbar instability at L3-4, blurred vision, sexual dysfunction, cervical disc lesion, headache, right knee derangement and right inguinal hernia. Furthermore, reports indicate that these conditions are not acute or subacute but specifically chronic in nature. The patient treatment history has included two epidural steroid injections with little pain resolution and L3-L4 lumbar vertebral body fusion. The most recent documentation submitted for review is from 5/01/2013 which indicates the patient is very depressed, tearful and reportedly under pressure due to his unemployment. Pain is said to be a major factor. The patient's current medications include Prozac 40 mg, Xanax 0.5 mg three times a day, Ambien 10 mg 2 at bedtime and Levitra 20 mg.

IMR DECISION(S) AND RATIONALE(S)

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

1. The intramuscular injection of Toradol 60mg on 6/26/13 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are a part of the MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG) Pain Chapter.

The Physician Reviewer's decision rationale:

The California MTUS/ACOEM is silent on the use of Toradol. However, the ODG indicate that oral formulation of Toradol should not be given as an additional dose only as continuation following intravenous (IV) or intramuscular (IM) dosing. Furthermore, guidelines indicate that IM injections of Toradol are not indicated for minor or chronic painful conditions. These injections are recommended for acute presentations as an alternative to opioid therapy. While medical records submitted for review in the case indicate that the employee is specifically being treated for chronic pain conditions, it would appear that the employee does not qualify under guidelines for the use of Toradol. Furthermore, the request specifically indicates that this decision is for the use of intramuscular injection of Toradol 60 mg on 6/26/2013. However, a careful review of the documentation provided fails to indicate that any records from such date have been submitted for review at this time. **The request for the intramuscular injection of Toradol is not medically necessary and appropriate.**

2. A discogram of the lumbar spine L2-L3, L3-L4 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, which are not a part of the MTUS.

The Physician Reviewer based his/her decision on the ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12, Low Back Complaints, pages 303-305, which are a part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS/ACOEM indicate that recent studies on discography do not support its use for use as a preoperative indication for either intradiscal/electrothermal annuloplasty or fusion. Discography does not identify the symptomatic high intensity zone and concordance of symptoms with a disc injected is of limited diagnostic value. Furthermore, careful review of the records provided for review fails to reveal any documentation from 6/26/2013 in which the basis for this request comes from. Due to the lack of support by the CA MTUS and the absence of documentation, this request for a discogram of the lumbar spine L2-L3, L3-L4 from 6/26/2013 cannot be supported. **The request for a discogram of the lumbar spine is not medically necessary and appropriate.**

3. An internal medicine consultation for surgical clearance is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 5, Cornerstones of Disability Prevention and Management, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS/ACOEM indicates that referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery or has difficulty obtaining information or agreement to a treatment plan. This case is being reviewed based on the 6/26/2013 request for an Internal Medicine consultation for surgical clearance.

However, after a careful review of the documentation provided for review, there are no records provided with this date. As such, the details surrounding the request are unknown leaving the rationale for this request unclear. **The internal medicine consultation for surgical clearance is not medically necessary and appropriate.**

4. The request for daily home health services is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Home Health Services, page 51, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS indicates that home health services are recommended only for otherwise recommended medical treatment for patients who are home bound on a part-time or intermittent basis, generally up to no more than 35 hours per week. While the guideline criteria does indicate that the use of home health services is recommended, there is a lack of documentation provided by the requesting physician specifically describing the home health care being requested (i.e. full-time nursing, hospice care, the medical condition being treated, etc). In addition, there is no evidence found in the records provided for review to support the claim that this employee is, in fact, home bound and would be the requirements for home health services. Given the lack of specific physician orders for frequency/duration/services of home health, as well as, the lack of confirmation that the employee is in fact homebound, the request for home health services cannot be supported at this time and is therefore non-certified. **The request for home health services is not medically necessary and appropriate.**

/dso

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