

<b>Case Number:</b>	CM13-0010230		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	08/09/2004
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	07/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2013

### 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 Illinois. 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 50-year-old female who reported an injury due to repetitive administrative office duties on 08/09/2004. In the clinical note dated 06/21/2013, the injured worker was annotated to participating in an interdisciplinary pain rehabilitation program which was an outpatient HELP program. The injured worker's diagnosis was annotated as degenerative cervical disc disease; spondylosis and stenosis; status post multilevel cervical fusion C4 to C7 dated 2007; myofascial pain syndrome; history of alcohol addiction; currently in recovery, major depressive disorder, recurrent, severe, without psychotic features; anxiety, NOS and panic; sleep disorder; loss of libido; and cognitive impairment by injured worker's history. It was annotated that the injured worker had completed 6 weeks of the HELP program. It was also noted that the injured worker completed the functional restoration program having made substantial progress towards her medical and functional goals. The injured worker's prescribed medication regimen included Naprosyn 500 mg, Cymbalta 60 mg and 30 mg, Flexeril 30 mg, and Ambien 10 mg. There was documentation of the injured worker having functional improvement dated from 01/07/2013- 06/21/2013. The baseline functioning test for lifting/carrying dated 01/07/2013 was 5 pounds and the baseline function testing for grip strength dated for the right 03/29/2013 was 45 pounds and the left dated 01/07/2013 at 22 pounds. For the functional activity for lifting and carrying baseline dated 03/29/2013 was 11 pounds and the lifting/carrying dated 06/21/2013 was 21 pounds. The functional activity of the grip strength dated 03/29/2013 for the right was 45 pounds, for the left was 35 pounds, and the grip strength dated 06/21/2013 noted right 50 pounds and the left 46 pounds. It was annotated that the injured worker had a sitting tolerance of 60 minutes, standing tolerance of 60 minutes, and a walking tolerance of 60 minutes. The work restrictions annotated for the injured worker were no forceful right side gripping, grasping, and fine manipulation, no lifting to exceed 20 pounds, no carrying to exceed 20 pounds, no push/pull

to exceed 40 pounds, no standing more than 60 minutes or 2 to 3 hours per day, no sitting more than 4 hours per day, no walking more than 60 minutes per hour 3 to 4 hours per day, no repetitive stairs/climbing, and no repetitive bending/stooping. It was annotated that the injured worker's performance, while sincere in effort, was mildly self limited due to a variety of factors which included fear of her injury and associated pain and fear avoidance behavior. The treatment plan included a request for in-office interdisciplinary reassessment in 4 months to determine appropriate recommendations and a reassessment to determine whether functional progress would be ongoing and what resources would be necessary to sustain or improve the injured worker's condition. Additionally, the direct reassessment would be recommended to establish interval measurement of progress. The request for authorization for 4 months HELP remote care and reassessment and equipment for the diagnosis of degenerative cervical disc disease, spondylosis and stenosis, myofascial pain syndrome, and major depression was submitted on 07/01/2013.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **4 MONTHS REMOTE CARE: 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 nic Pain Medical Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30.

**Decision rationale:** The request for 4 months remote care is non-certified. The California MTUS guidelines state that chronic pain programs (functional restoration programs), are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. It was annotated that the injured worker had made substantial progress towards her medical and functional goals. Furthermore, the guidelines state that longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility of which the clinical notes did not address. Therefore, the request for 4 months remote care is not medically necessary and appropriate.

#### **INTERDISCIPLINARY REASSESSMENT: 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 Chronic pain programs (functional restoration programs) Page(s): 30.

**Decision rationale:** The request for interdisciplinary reassessment is non-certified. The California MTUS guidelines state that chronic pain programs (functional restoration programs), are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. In the clinical notes provided for review, it was annotated that the injured worker had made substantial progress towards her medical and functional goals. Furthermore, the request for remote care is non-certified exempting the need for interdisciplinary reassessment. Therefore, the request for interdisciplinary reassessment is not medically necessary and appropriate.