

Case Number:	CM13-0015238		
Date Assigned:	10/11/2013	Date of Injury:	05/20/2013
Decision Date:	02/03/2014	UR Denial Date:	08/05/2013
Priority:	Standard	Application Received:	08/22/2013

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 Occupational Medicine, 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. 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 applicant is a represented [REDACTED], employee who has filed a claim for chronic low back and left shoulder pain reportedly associated with an industrial injury of May 20, 2013. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; unspecified amounts of chiropractic manipulative therapy; and extensive periods of time off of work, on total temporary disability. In a utilization review report of August 5, 2013, the claims administrator denied a functional restoration program, denied a functional capacity evaluation, denied computerized range of motion measurements, denied a lumbar support, denied an interferential unit, denied a pharmacological consult, and denied topical compounds. Naprosyn, a followup office visit, MRIs, and chiropractic manipulative therapy were all approved. The claims administrator did not provide any supporting rationale. The applicant's attorney later appealed. In an August 21, 2013 appeal letter, it is stated that a functional capacity evaluation is being sought prior to pursuit of a functional restoration program/work hardening regimen. The attending provider uses the terms functional restoration program and work hardening program interchangeably. The applicant reports persistent low back and shoulder pain, it is noted. An earlier note of August 6, 2013, with a physiatrist is notable for comments that the applicant reports persistent low back and left shoulder pain. Positive signs of internal derangement are noted about the shoulder. The applicant does have a normal neurologic exam about the upper extremities. The applicant's lumbar and shoulder range of motion are apparently improved. "Functional restoration therapy for another six visits" is sought along with MR imaging studies and a formal functional restoration program. The applicant is placed off of work, on total tempor

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program (FRP) times 6 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 32.

Decision rationale: As noted on page 32 of the MTUS Chronic Pain Medical Treatment Guidelines, criteria for pursuit of a functional restoration program include evidence that previous means of treating chronic pain have been unsuccessful and that there is absence of other options likely to result in significant clinical improvement. The applicant should not be a candidate for whom surgery or other treatments would be indicated. In this case, however, it is not clearly stated or suggested that the applicant is not a candidate for a surgical remedy. It does not appear that the applicant in fact consulted a surgeon. The request, it is incidentally noted, was initiated on or around the three-month mark of the date of injury. It does not clearly appear that all lesser levels of care have been exhausted before the program was sought. For all of these reasons, then, the request is not certified.

Functional capacity evaluation (FCE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 125.

Decision rationale: While page 125 of the MTUS Chronic Pain Medical Treatment Guidelines does suggest that functional capacity evaluations can be employed as a precursor to a work hardening program, in this case, the functional restoration program with a work hardening element was not certified, in question #1, on the grounds that the applicant had not exhausted lower levels of care. In this case, by definition, the proposed precursor functional capacity evaluation (FCE) is likewise not indicated and not certified.

Computerized range of motion (ROM) measurements: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, range of motion measurements of the low back are of limited value, because of the marked variation in

those applicants with and without symptoms. Thus, ACOEM deems range of motion measurements of the lumbar spine are of questionable value, even without the addition of computerized measurements. Similarly, the MTUS-adopted ACOEM Guidelines in Chapter 9 also suggest that range of motion of the shoulders should be determined actively and passively. In this case, however, the attending provider is seeking computerized range of motion testing. ACOEM does not establish a role for the same. Therefore, the request is not certified.

IF Unit: 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 Page(s): 120.

Decision rationale: As noted on page 120 of the MTUS Chronic Pain Medical Treatment Guidelines, interferential current stimulation can be employed in those individuals in whom pain is inadequately controlled owing to diminished medication efficacy, those individuals with a history of substance abuse in whom usage of analgesic medications is unwise, and/or those individuals who have significant pain issues which prevent or limit the ability to perform physical therapy or other conservative measures. In this case, however, none of the aforementioned criteria have clearly been met. The attending provider does not clearly detail or document issues with diminish medication efficacy or issues with medication intolerance or issues with substance abuse. It is further noted that the request for the device was sought as a purchase of the same without an intervening 1-month trial of the same, which is considered a prerequisite for purchase of the device, per page 120 of the MTUS Chronic Pain Medical Treatment Guidelines. For all of these reasons, then, the request is not certified.

LSO: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In this case, the attending provider has not clearly furnished any rationale to try and offset the unfavorable ACOEM recommendation. The applicant is/was several months removed from the date of injury, as of the date of the request. Continued usage of a lumbar support at that point in time was not indicated as it would only have served to promote further immobility and disuse, neither of which are to be recommended. Therefore, the request is not certified.

Pharmacological consult: Overturned

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 Page(s): 1.

Decision rationale: As noted on page 1 of the MTUS Chronic Pain Medical Treatment Guidelines, the presence of persistent complaints should lead a primary treating provider to reconsider the operating diagnosis and determine whether a specialist evaluation is necessary. In this case, the applicant's primary treating provider is apparently a chiropractor who is not licensed to prescribe medications. Obtaining the added expertise of a physician who is licensed to prescribe medications is indicated and appropriate. Therefore, the request is certified.

FluFlex Cream, TGHot cream and Naproxen: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Page(s): 111.

Decision rationale: As noted on page 111 of the MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are "largely experimental." In this case, there is no evidence of intolerance to and/or failure of multiple classes of first-line oral pharmaceuticals so as to justify usage of the proposed largely experimental topical compounds.

Naprosyn: 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 Page(s): 22.

Decision rationale: While page 22 of the MTUS Chronic Pain Medical Treatment Guidelines does suggest that anti-inflammatory medications such as Naprosyn do represent the traditional first-line of treatment for chronic pain conditions, in this case, the applicant had been issued several prior prescriptions for Naprosyn, an NSAID. The applicant's subsequent failure to return to any form of work implied a lack of functional improvement as defined in MTUS 9792.20(f). Continuing Naprosyn in this context is not indicated. Therefore, the request is not certified.