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| Case Number: | CM13-0034862 | | |
| Date Assigned: | 12/11/2013 | Date of Injury: | 10/02/2001 |
| Decision Date: | 08/07/2014 | UR Denial Date: | 09/26/2013 |
| Priority: | Standard | Application Received: | 10/15/2013 |

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 Orthopedic Surgery 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 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:

This claimant is 42-year-old male, who was injured on October 2, 2001. The records provided for review document that the claimant underwent a lumbar fusion at L4-S1. The claimant's current working diagnoses include: back syndrome; status post lumbar spine fusion and the subsequent removal of hardware; depression; and left shoulder rotator cuff repair. At a November 7, 2013 office visit, the claimant reported numbness, pain, insomnia, anxiety, depression and activity limitation. The conservative treatment has included rest, activity modification, trigger point injections and heat. The physical examination findings showed non-specific tenderness in the left shoulder, tenderness of the acromioclavicular joint, positive impingement testing of the left shoulder, positive apprehension testing, limited shoulder range of motion bilaterally, diminished biceps reflex, positive straight leg raise, severe paraspinal lumbar tenderness, muscle guarding and spasm, limited lumbar range of motion, and normal deep tendon reflexes. This request is for a functional restoration program, a trigger point injection, four (4) hours of home health care for four (4) hours per week, transportation and a compound of Ketoflex and Flur.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 31-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs); Functional restoration programs (FRPs) Page(s): 31-32, and 49.

Decision rationale: The Chronic Pain Guidelines recommend functional restoration programs for no longer than two (2) weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. In this case, the request for a functional restoration program did not specify the length of participation. In addition, the reviewed records do not document objective findings, which would make it difficult to identify any objective gains that may result from participation in a functional restoration program. For these reasons, this request would not be supported as medically necessary.

Trigger point injection of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Criteria for use of trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: The Chronic Pain Guidelines recommend trigger point injections in two-month intervals and allow for repeat injections when claimant's experience at least a fifty (50) percent improvement in pain for more than six (6) weeks and have an associated reduction in medication and increase in activity. In this case, the reviewed records do not document the time that has elapsed since the prior trigger point injection or address the effectiveness of the injection in reducing pain and improving function. Therefore, this request is not established as medically necessary.

Home health care four (4) hours per day for four (4) days a week: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, and on the Non-MTUS <http://www.medicare.gov/Publications/Pubs/pdf/10969.pdf>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: The Chronic Pain Guidelines recommend home health care in claimants who are homebound on a part-time or intermittent basis. The records reviewed in this case do not suggest that the claimant is homebound. Therefore, this request is not established as medically necessary.

Transportation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical Practice Standard of Care.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83.

Decision rationale: The MTUS/ACOEM Guidelines recommend transportation in cases in which the claimant is unable to either provide his or her own transportation or obtain it elsewhere. The reviewed records do not address the claimant's transportation status, or otherwise suggest that the claimant is medically incapable of providing it. Therefore, this request is not established as medically necessary.

Compound medication: Ketoflex and Flur-20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-114.

Decision rationale: The Chronic Pain Guidelines indicate that the request for compound medication of Ketoflex and Flur-20 would not be indicated as medically necessary. The guidelines indicate that most studies on the effectiveness of anti-inflammatory topical agents have been inconsistent and that there is a lack of medical support in the literature for the use of such agents. Therefore, this request would not be supported.