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| Case Number: | CM13-0041961 | | |
| Date Assigned: | 12/20/2013 | Date of Injury: | 01/26/2011 |
| Decision Date: | 04/22/2014 | UR Denial Date: | 10/08/2013 |
| Priority: | Standard | Application Received: | 10/06/2013 |

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 & Rehabilitation, has a subspecialty in Interventional Spine 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:

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records: This patient is a 33-year-old male with a date of injury of 01/26/2011. Per treating physician's report from 08/20/2013, the listed diagnoses are: 1. Discogenic lumbar condition with facet inflammation and periodic radiculopathy. 2. Right ankle sprain/strain. 3. Element of depression and anxiety with 50-pound weight gain, sleep dysfunction, gastritis, and headaches. The patient has constant pain at 6/10 to 7/10 in low back and right ankle, worse in the low back which is at 7/10 to 8/10. The patient has occasional spasm radiating into the neck, swelling of the right ankle with prolonged walking, numbness and tingling in the low back and radiates to the back of the right thigh. The patient has decreased level of activities due to chronic pain, currently not working. Under recommendations, the treater was appealing the denial of the TENS unit, also recommended hot/cold wrap and a back brace, which will help his pain. Report of lumbar MRI from 03/18/2011 shows multilevel mild ligamentum flavum hypertrophic facet changes, but no evidence of disk herniation or bulge. Review of the report from 10/03/2013 showed that there is a request for repeat RF ablation. However, despite review of multiple reports from 2013, from 03/08/2013 to 11/27/2013, it does not discuss the request for Functional Restoration Program.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF HOT/COLD WRAP: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines.

Decision rationale: The Expert Reviewer's decision rationale: This patient presents with chronic low back pain and ankle pain. The request for hot/cold wrap, MTUS Guidelines do not discuss hot/cold wraps, but ODG Guidelines does support heat therapy for low back pain, stating that it is recommended as an option with a number of studies showing continuous low level of heat wrap therapy to be effective in treating low back pain. Given the patient's persistent low back pain, hot/cold wrap is reasonable and recommendation is for authorization.

PURCHASE OF BACK BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines.

Decision rationale: This patient presents with chronic low back pain with MRI demonstrating degenerative disk changes along with facet hypertrophy only without disk herniation or stenosis. The treating physician has asked for purchase of lumbar brace. ACOEM Guidelines page 301 under lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines also does not support lumbar brace except for treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. However, ODG Guidelines states that for nonspecific low back pain, there was very low quality evidence, but maybe a conservative option. This patient presents with nonspecific low back pain and given the low level of evidence and lack of support from ACOEM Guidelines, recommendation is for denial.

FUNCTIONAL RESTORATION PROGRAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines Page(s): 30-32.

Decision rationale: This patient presents with chronic low back pain with MRI demonstrating facet hypertrophic changes without disk herniation or stenosis. The patient is on multiple

medications including morphine sulfate. There is a request for Functional Restoration Program. However, despite review of reports from 03/08/2013 to 11/27/2013 consisting of 11 reports by [REDACTED] and [REDACTED], I was not able to find a report discussing the request for Functional Restoration Program. MTUS Guidelines does support Functional Restoration Program, but requires careful initial evaluation to rule out negative predictors of success. In this case, the generic request for Functional Restoration Program cannot be recommended for authorization. The patient's initial consultation and evaluation is missing. Duration and the frequency of treatment are missing and the request. Without this information, this request cannot be considered for authorization. MTUS Guidelines allows up to initial 2 weeks of program and additional treatments with documentation of improvement. Again, initial evaluation is necessary before a full program can be considered. Recommendation is for denial.