

Case Number:	CM13-0052454		
Date Assigned:	12/27/2013	Date of Injury:	06/17/2011
Decision Date:	04/30/2014	UR Denial Date:	09/04/2013
Priority:	Standard	Application Received:	11/15/2013

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 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 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 patient is a 36 year old male with a June 17, 2011 date of injury described as cumulative trauma. A CT of the lumbar spine without contrast performed September 16, 2013 revealed post operative status at L4-L5 and L5-S1; narrowing of L5-S1. CT of the lumbar spine performed July 22, 2013 revealed narrowing of L5 - S1, postoperative status and minimal disc bulging at L3-4 and L4-5. X-rays of the lumbar spine seven views performed on March 28, 2013 revealed post operative status in the lower lumbar spine. X-rays of the lumbar spine multiple views performed December 26, 2012 revealed post operative status for spinal fusion and straightening of the normal lordosis perhaps due to muscle spasms. An interim functional capacity evaluation was performed on July 15, 2013. Thus far treatment has included more than 20 postoperative physical therapy sessions which did not result in significant improvement; 24 sessions of work hardening/FRP with no significant decreases in pain or increases in function. On December 6, 2012 the patient had L4-L5 and S1 laminectomy with bilateral medial facetectomy, body fusion from L4 to S1. The records indicate the patient's surgeon is considering a second operation at this time. The patient's treating physicians submitted a request for authorization on August 20, 2013 to include a functional restoration program, therapy six visits at three times weekly for two weeks, electrical muscle stimulation to the lumbar spine, infrared lumbar spine, and a functional capacity evaluation. Progress note prior to the request documented complaints of constant lumbar pain and leg pain in the bilateral arms with numbness to the arm. Physical examination revealed spasms and tenderness to bilateral lumbar paraspinal muscles from L1 to S1, positive Kemps test bilaterally, positive straight leg raising bilaterally, decreased right Achilles reflex tendon, and decreased range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

FUNCTIONAL RESTORATION PROGRAM (FOLLOW UP VISIT OR EQUIVALENT):

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: According to the MTUS Chronic Pain Guidelines, functional restoration programs are recommended as a type of treatment however long-term evidence suggests that the benefit of the programs diminish over time. The criteria for general use of multidisciplinary pain management programs (FRP) state an adequate and thorough evaluation must be made including baseline functional testing; previous methods of treating chronic pain have been unsuccessful; the patient has significant loss of ability to function independently resulting from chronic pain; the patient is not a candidate for surgery or other treatments would clearly be warranted. The MTUS Chronic Pain Guidelines state treatment is not suggested for longer than two weeks without evidence of demonstrated efficiency as documented by subjective and gains. There is no documentation of the patient's subjective gains through the records provided and therefore the request is not medically necessary and appropriate.

THERAPY 6 VISITS AT 3 TIMES WEEKLY FOR 2 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: According to the MTUS Postsurgical Treatment Guidelines, postsurgical treatment for fusion includes up to 34 visits over 16 weeks. Documentation submitted for review states the patient has received approximately 25 physical therapy sessions as the initial course of therapy. The guides further state that with documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters. Throughout the documentation submitted there is no indication of functional improvement but rather documentation that the patient has gotten worse. Consequently, the request is not medically necessary and appropriate.

ELECTRICAL MUSCLE STIMULATION TO THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 116.

Decision rationale: The request for electrical stimulation is not recommended by the MTUS Chronic Pain Guidelines as a treatment option for postoperative pain in excess of the first 30 days post surgery. The request is therefore not medically necessary and appropriate.

INFRARED TO THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back

Decision rationale: According to the ODG, infrared therapy is not recommended over other heat therapies. The request is therefore not medically necessary and appropriate.

FUNCTIONAL CAPACITY EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7 page 511

Decision rationale: The ACOEM Guidelines state the employer or claim administrator may request this test to assess current work capabilities. It further states that it may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial. ACOEM Guidelines also state, "There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities." There is no documentation throughout the medical documentation to support the crucial need for this test. The request is not medically necessary and appropriate.