

<b>Case Number:</b>	CM13-0065705		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	04/07/2011
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	11/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/13/2013

### 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 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 patient is a 32-year-old male who reported an injury on 04/07/2011. The mechanism of injury was a fall. The Integrative Summary Report dated 10/11/2013 indicated that the patient participated in the HELP functional restoration program from 09/19/2013 through 10/10/2013 (for 3 weeks total). The patient demonstrated body mechanics, increased exercise, task persistence, pacing, avoiding pain contingent rest intermittently, ignoring pain intermittently, avoiding guarding, using relaxation techniques, using positive self-statements and avoiding Catastrophizing. It was noted medically that the patient discontinued his tramadol early in the course of the treatment and was currently utilizing anti-inflammatories for the management of his pain. Functionally, the patient was able to increase all of his tolerances. It was noted that the patient was authorized to receive 6 weeks of part day treatment of interdisciplinary care and would continue per the current treatment plan to attain additional progress on the stated medical and functional goals. It was noted that on 08/30/2013, the patient's medications included tramadol, omeprazole, GABAdone and Theramine as well as Diclofenac sodium. As of 10/11/2013, the patient's medications included omeprazole, GABAdone, Theramine, Diclofenac Sodium and Ibuprofen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Decision for 4 months of HELP remote care reassessment (1 weekly call x 4 weeks): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain, chronic pain programs (functional restoration programs)

**Decision rationale:** The request for 4 months of HELP remote care reassessment (1 weekly call times 4 weeks) is non-certified. The California MTUS/ACOEM does not address HELP remote care. However, the Official Disability Guidelines state that for chronic pain programs (functional restoration programs), post-treatment medication management is particularly important. Patients who have been identified as having substance abuse issues generally require some sort of continued additional follow-up to avoid relapse. The records submitted for review failed to include documentation that the patient had been identified as having substance abuse issues. In addition, the records submitted for review included the medication as of 10/11/2013 to be omeprazole, GABAone, Theramine, diclofenac sodium and ibuprofen, which does not include opioids or other medications that would need close monitoring. Therefore, the request of decision for 4 months of help remote care reassessment (1 weekly call x 4 weeks) is not medically necessary and appropriate.

**Decision for reassessment at end of remote program in office:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.