

Case Number:	CM14-0001223		
Date Assigned:	01/22/2014	Date of Injury:	02/20/2009
Decision Date:	06/19/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/03/2014

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 45-year-old male who has submitted a claim for mechanical low back pain, disc herniation at L4-5 and L5-S1, chronic intractable pain, and osteoarthritis of the left knee associated with an industrial injury date of February 20, 2009. Medical records from 2013 were reviewed, the latest of which (December 11, 2013) revealed that the patient complains of low back, shoulder, and knee pain. He completed the HELP program on November 11, 2013 and is made substantial goals both medically and functionally. The patient has better body mechanics, increased exercise tolerance, intermittent task persistence, and relaxation techniques. Medical progress was made by demonstrating decreased assistance in daily activities. Disease specific education was also completed. Treatment to date has included arthroscopic subacromial decompression of the right shoulder and arthroscopic right distal clavicular excision (April 7, 2010), HELP program (completed on November 11, 2013), chiropractic therapy, physical therapy, an exercise program, activity adjustment, electrical stimulation, manual therapy, and medications which include carisoprodol, ibuprofen, Vicodin, cyclobenzaprine, Tylenol, Skelaxin, and hydrocodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 MONTHS HELP REMOTE CARE, WEEKLY CALL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CHRONIC PAIN PROGRAMS,

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

Decision rationale: As stated on pages 31-32 of the California MTUS Chronic Pain Medical Treatment Guidelines, continued functional restoration program participation is recommended with demonstrated efficacy as documented by subjective and objective gains. Additionally, the Official Disability Guidelines state that treatment post-functional-restoration-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified. In this case, the patient has recently completed the HELP program last November 22, 2013 with noted medical progress and functional improvements. However, the total number of sessions is unknown. It is unclear why follow-up with regular office visits would be insufficient. As such, the request is not medically necessary.

A FOUR HOUR REASSESSMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CHRONIC PAIN PROGRAMS,

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.