

Case Number:	CM14-0001708		
Date Assigned:	01/22/2014	Date of Injury:	05/15/2012
Decision Date:	06/23/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	01/06/2014

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 Physical Medicine and Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 31-year-old male who reported an injury on 05/15/2012. The mechanism of injury was a motor vehicle accident. Per the initial evaluation note dated 02/07/2013, the injured worker complained of sharp, stabbing, aching, and radiating pain to the left lower back and left hip rated 9/10 at the worst and 5/10 at the best. On physical examination, the injured worker was noted to have decreased range of motion in the left lower extremity, weakness in the left lower extremity due to increased pain and weight on the left lower extremity. Per the same evaluation, the provider noted an MRI of the lumbar spine was largely unremarkable as was the left hip MRI; however, there was no date for either of the studies. An electrodiagnostic study was performed, and was found to be unremarkable; the date of the evaluation was unclear. It was reported that the injured worker participated in both aquatic and land-based physical therapy but had trouble tolerating the exercises. He had not currently been participating in any type of home exercise program that was improving his function. Per the clinical note dated 09/10/2013, the injured worker ambulated with assistance of a single point cane. He had full strength to his bilateral lower extremities, although it did take some coaching to generate on the left. The diagnoses for the injured worker included axial low back pain with overlying myofascial pain; rule out left hip labral tear, left piriformis strain. The Request for Authorization of medical treatment was dated 11/27/2013. The request was for admission to a functional restoration program 5 days a week for 6 weeks for axial low back pain with overlying myofascial pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

FUNCTIONAL RESTORATION PROGRAM FIVE (5) DAYS PER WEEK FOR SIX (6) WEEKS: 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 (FUNCTIONAL RESTORATION PROGRAMS), 31-32

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

Decision rationale: The California MTUS Guidelines recommend functional restoration where there is access to programs with proof of successful outcomes for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains and total treatment duration should generally not exceed 20 full day sessions. Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. The guidelines note outpatient pain rehabilitation programs may be considered medically necessary after an adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement, when previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, and the patient has a significant loss of ability to function independently resulting from the chronic pain. The guidelines note patients should exhibit motivation to change, and be willing to forgo secondary gains, including disability payments to effect this change. The documentation provided stated the injured worker previously participated in aqua therapy as well as physical therapy without benefit due to pain restraints. In addition, the documentation stated the injured worker was highly motivated to return to work. The documentation stated a thorough evaluation was performed; however, there was a lack of documentation regarding the evaluation. The guidelines recommend a 2 week trial with demonstrated efficacy before continuing with a functional restoration program; however, the injured worker has not participated in a trial of the program. In addition, the guidelines recommend the total treatment period should not exceed 20 full day visits. Therefore, the request for the functional restoration program 5 days a week for 6 weeks is not medically necessary.