

Case Number:	CM14-0003009		
Date Assigned:	01/29/2014	Date of Injury:	06/28/2003
Decision Date:	08/12/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/08/2014

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 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 injured worker is a 54-year-old female who reported an injury on 06/28/2003, where she tried to catch a resident's fall. The injured worker was participating in an outpatient [REDACTED] [REDACTED] which is an interdisciplinary pain rehabilitation program. The injured worker was reporting improvement in pain. The injured worker had a physical examination on 02/19/2014. The injured worker had complaints of pain, but stated it was more controlled. The injured worker also stated that Lyrica 150 mg 3 times a day was beneficial for neuropathic pain. Cervical range of motion revealed limitations in all directions. Tight muscles were noted in the shoulders. Upper and lower extremity range of motion was functional. Strength in upper extremities was 4/5 bilaterally. Medications for the injured worker were Lyrica, Ambien, and Amitiza. The injured worker was also on another medication that was stated as "blinded pain cocktail m6 to m7." Also, the injured worker was to start Zanaflex. Diagnoses were unspecified myalgia and myositis, cervicgia, post laminectomy syndrome cervical region. The rationale and Request for Authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

FOUR MONTH [REDACTED] REMOTE CARE (ONE CALL PER WEEK): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 49.

Decision rationale: The request for 4 month [REDACTED] remote care (1 call per week) is not medically necessary. The California Medical Treatment Utilization Schedule states Functional Restoration Programs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. Long-term evidence suggests that the benefit of these programs diminishes over time. Treatment is not suggested for no longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The injured worker participated in a [REDACTED] [REDACTED] which is an interdisciplinary pain rehabilitation program. This was a six week program. The injured worker reported increased independence in exercise and functional activities, improved understanding of level of level 1 posture, control, and core strength, increasing level of participation, co-operation, and attention to tasks, decreased fear of functional activities, and increasing interest and willingness to consider the value of increased function. However, the guidelines indicate treatment of this type is not suggested for longer than 2 weeks. Therefore, the request exceeds guideline recommendations. Therefore, the request is not medically necessary.

REASSESSMENT-ONE VISIT,FOUR HOURS: 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 Page(s): 49.

Decision rationale: As the primary request for four month [REDACTED] remote care (one call per week) is not supported, the ancillary request for reassessment 1 visit 4 hours is also not supported. Therefore, the request is not medically necessary.

THERACANE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The request for TheraCane is not medically necessary. This product applies pressure to treat muscle dysfunction which can be used at home in the shower. The Official Disability Guidelines states durable medical equipment is generally recommended if there is a medical need. Durable medical equipment can be defined as equipment that can withstand repeated use, could be rented, or used by successive patients. The guidelines state that the product should customarily be used to serve a medical purpose. It also states that the product

should not be useful in the absence of illness or injury. The medical necessity and rationale for the use of the TheraCane were not reported. It also was not reported if this was for a purchase or a rental. Therefore, the request is not medically necessary.

PHYSIOBALL (65CM): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The request for physioball (65cm) is not medically necessary. This product applies pressure to treat muscle dysfunction which can be used at home in the shower. The Official Disability Guidelines states recommended generally if there is a medical need. Durable medical equipment can be defined as equipment that can withstand repeated use, could be rented, or used by successive patients. The guidelines state that the product should customarily be used to serve a medical purpose. It also states that the product should not be useful in the absence of illness or injury. The medical necessity and rationale for the use of the Physioball were not reported. It also was not reported if this was for a purchase or a rental. Therefore, the request is not medically necessary.