

Case Number:	CM14-0003130		
Date Assigned:	01/31/2014	Date of Injury:	03/11/2010
Decision Date:	06/19/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/09/2014

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 56-year-old female who has submitted a claim for major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior and Degeneration of lumbar or lumbosacral intervertebral disc associated with an industrial injury date of March 11, 2010. The patient complains of chronic low back pain. Physical examination showed a diffuse lumbar myofascial pain and a slightly antalgic gait. The diagnoses include status post L4-5 and L5-S1 anterior discectomy and lumbar fusion (2011), lumbar degenerative disc disease, axial low back pain, lumbar radiculopathy, lumbar myofascial pain, anxiety disorder and severe depression. The patient has made commendable progress towards her medical and functional goals upon completion of [REDACTED] program on November 15, 2013. [REDACTED] interdisciplinary remote care services were requested to transition the patient. Also, an interdisciplinary reassessment was requested to determine whether such functional progress is ongoing, what resources are necessary to sustain or improve the patient's condition, and to establish interval measurement of progress. Treatment to date has included oral and topical analgesics, antidepressants, lumbar spine surgery, home exercise program, aqua therapy, physical therapy and functional restoration program. Utilization review from December 12, 2013 denied the requests for [REDACTED] program and interdisciplinary re-assessment because there was no documentation of a compelling rationale for the need of further treatment beyond the completion of the formal restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

FOUR MONTHS OF ██████ PROGRAM, REMOTE CARE, 1 WEEKLY CALL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration. Decision based on Non-MTUS Citation ODG Pain (updated 11/14/13).

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

Decision rationale: Page 31-32 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that continued functional restoration program (FRP) participation is supported with demonstrated efficacy as documented by subjective and objective gains. Additionally, guidelines state that total treatment duration should generally not exceed 20 sessions without a clear rationale for the specified extension and reasonable goals to be achieved. In this case, the patient has completed 6 weeks of direct ██████ program as of November 15, 2013 with documented subjective and objective gains. The patient has met the standing goal but has come up slightly short of the lifting and walking goal. However, the patient has been instructed in a home exercise program, which will suffice in achieving the minimal residual deficits. The functional benefit of a weekly call is not clear. The medical necessity has not been established due to lack of compelling rationale for the need of a continued course of treatment. Therefore, the request for four months of ██████ Program, Remote Care, 1 weekly call is not medically necessary.

INTERDISCIPLINARY REASSESSMENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs. Decision based on Non-MTUS Citation ODG Pain (updated 11/14/13).

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

Decision rationale: The request for four months of ██████ Program, Remote Care, 1 weekly call is not medically necessary. Therefore, the dependent request for Interdisciplinary reassessment is also not medically necessary.