

Case Number:	CM14-0007153		
Date Assigned:	02/07/2014	Date of Injury:	07/06/2009
Decision Date:	07/17/2014	UR Denial Date:	01/10/2014
Priority:	Standard	Application Received:	01/20/2014

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, has a subspecialty in Pain Management 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:

This is a 44-year-old male with a 2009 date of injury. Mechanism is documented while lifting boxes. Records indicate that the patient had been recommended for lumbar spine surgery and injections however the patient does not wish to have any procedures. There is a documented chronic pain syndrome with patient reports of depression and hopelessness, and anxiety. It is noted that the patient takes OxyContin 80 mg one tablet p.o. t.i.d. and Flexeril. Pain level even with medications is 8.5/10MRI reportedly showed facet arthropathy at L5 with a small disk protrusion at L5-S1 and L4-5 with facet arthritis. Electrodiagnostic studies in 2010 showed no evidence of lumbosacral radiculopathy. Treatment requested was a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

FUNCTIONAL RESTORATION PROGRAM FOR SYMPTOMS RELATED TO THE LUMBAR SPINE AS AN OUTPATIENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-32.

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

Decision rationale: The prior adverse determination was reviewed for lack of documentation of lower levels of care including therapy, chiropractic, or injections. In the context of this request, no additional medical records were provided. There is no provision of an official MRI to review, and no objective evaluation of what is causing this patient's chronic pain. Apparently, surgery and injections have been recommended as a potential alleviating factor however the patient declines for an unknown reason. There is a significant psychological overlay where there has not been any description of individual psychologic treatments. The MTUS guidelines states that there should be adequate documentation that previous methods of treating chronic pain have been unsuccessful and that there is an absence of other options likely to result in significant clinical improvement. This has not been adequately demonstrated. Non-certify.