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| <b>Case Number:</b>   | CM14-0134513 |                              |            |
| <b>Date Assigned:</b> | 08/27/2014   | <b>Date of Injury:</b>       | 12/20/2002 |
| <b>Decision Date:</b> | 11/03/2014   | <b>UR Denial Date:</b>       | 08/08/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/20/2014 |

### 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 Internal 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 61 year old male who was injured on 12/20/2012. He sustained an injury to his neck and back when he fell backwards. Prior treatment history has included Methadone, Clonazepam, Cymbalta, Gabapentin, and Oxycodone. Follow-up 07/08/2014 documented the patient to have complaints of neck pain and low back pain rated as an 8/10. He described the pain as achy and sharp radiating into the thigh. It was noted that there was no evidence of medication dependency. On physical exam, paravertebral muscle tenderness and hypertonicity of the lumbar spine bilaterally. The neck revealed restricted range of motion with flexion limited to 35 degrees; extension limited to 25 degrees; left lateral bending limited to 20 degrees; right lateral bending limited to 25 degrees; left lateral rotation to 70 degrees; and right lateral rotation to 65 degrees. The patient is diagnosed with cervicalgia, spinal stenosis of the lumbar region; lumbago; and thoracic or lumbosacral neuritis or radiculitis, NOS. The patient was recommended for a multidisciplinary evaluation at the [REDACTED]. Prior utilization review dated 08/08/2014 states the request for Multidisciplinary Evaluation for [REDACTED] is denied as medical necessity has not been established.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Multidisciplinary Evaluation for [REDACTED]:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs); Criteria for the genera; u.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Independent Medical Examination & Consultation, page(s) 503

**Decision rationale:** The guidelines recommend functional restoration programs/multidisciplinary evaluation for patients suffering from chronic pain. The programs are designed for patients with chronic musculoskeletal pain and focus on improved function rather than elimination of pain. The patient continues to complain of severe pain which significantly limit his level of functioning. The patient continues to experience these severe symptoms despite multiple medications and conservative care. The treating physician is considering multiple treatment options but it is likely the patient will benefit from a multidisciplinary evaluation. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is medically necessary.