

Case Number:	CM14-0136814		
Date Assigned:	09/03/2014	Date of Injury:	11/24/2003
Decision Date:	10/02/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/25/2014

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:

The patient is a 64-year-old female with a date of injury of 11/24/2003. The listed diagnoses per [REDACTED] are Mechanical low back pain, Discogenic low back pain, Lumbar sacral spinal stenosis, Postlaminectomy syndrome, and Chronic pain syndrome. According to progress report 07/21/2014, the patient continues with chronic low back pain and has participated in multiple prior treatments including medications, steroid injections, and physical therapy. The patient had a discectomy in 1989, repeat discectomy in 1990, and then an L4-L5 discectomy with fusion in 1994. Examination revealed decreased range of motion and lower extremity strength was 5/5 throughout the lower extremities. Range of motion was within functional limits. Patient's medication regimen includes OxyContin 20 mg, oxycodone 15 mg, and oxycodone 50 mg. Treater recommends an evaluation for participation in the HELP Functional Restoration Program. Utilization review denied the request on 08/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

consult with the Help program: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Chronic pain programs;

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

Decision rationale: This patient presents with chronic low back pain and is status post multiple low back surgeries. The treater is requesting an evaluation for the HELP Functional Restoration Program. The MTUS page 30 to 33 recommends functional restoration programs and indicates if may be considered medically necessary when all criteria are met including, (1) adequate and thorough evaluation has been made, (2) previous methods of treating chronic pain have been unsuccessful, (3) significant loss of ability to function independently resulting from the chronic pain, (4) not a candidate for surgery or other treatment would clearly be, (5) the patient exhibits motivation to change, (6) negative predictors of success above have been addressed. In this case, the treater is requesting an evaluation to determine if the patient would be a good candidate for the program. MTUS requires a thorough evaluation before consideration in the program is made. The request for consult with the HELP program is medically necessary or appropriate.