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| Case Number: | CM14-0152887 | | |
| Date Assigned: | 09/23/2014 | Date of Injury: | 04/22/2003 |
| Decision Date: | 10/24/2014 | UR Denial Date: | 08/21/2014 |
| Priority: | Standard | Application Received: | 09/19/2014 |

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 & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California & Washington. 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 67-year-old female who reported an injury on 04/22/2003 after a fall down a set of stairs. The injured worker reportedly sustained an injury to multiple body parts and suffered emotional distress. The injured worker's treatment history included multiple medications on psychological support. The injured worker was evaluated on 08/12/2014. It was documented that the injured worker complained of 7/10 low back pain that caused sleep disturbances. Physical findings included restricted range of motion secondary to pain with 2/4 pulses of the bilateral lower extremities and 4/5 motor strength of the right lower extremity. The injured worker had tenderness to palpation of the sacroiliac joint. It was noted that the injured worker did not consistently ambulate. The injured worker's medications included Cymbalta for depression, Ultram 50 mg for pain control, and Zanaflex for pain control. The injured worker's diagnoses included low back pain, right lumbar radiculopathy/lumbar spondylosis, degenerative disc disease of the lumbar spine, insomnia, sacroiliac joint dysfunction, and depression. The injured worker's treatment plan included continuation of medications and a functional restoration program evaluation and a comprehensive chronic pain clinical evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ativan 1mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The clinical documentation submitted for review does indicate that the injured worker has been on this medication for over a year. The California Medical Treatment Utilization Schedule does not recommend the long term use of benzodiazepines due to a high risk of dependence both physically and psychologically. The clinical documentation does indicate that the injured worker has already been on this medication to exceed the recommended duration of treatment. There were no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ativan 1 mg #120 is not medically necessary or appropriate.

Functional Restoration Program Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Functional Restoration Programs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration program), Page(s): 36.

Decision rationale: The requested functional restoration program evaluation is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends a functional restoration program for patients who have exhausted all lower levels of treatment and are not surgical candidates. The clinical documentation submitted for review does not provide any evidence that the injured worker has received any type of conservative treatment within the last year other than medication management. Therefore, the need for a functional restoration program is not indicated in this clinical situation. As such, the requested functional restoration program evaluation is not medically necessary or appropriate.

Chronic Pain Clinic Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The American College of Occupational and Environmental Medicine recommend referral services for patients at risk for delayed recovery when the referring physician has exhausted all diagnostic and conservative treatments within their scope of practice.

The clinical documentation does not provide any evidence that the injured worker has been provided any conservative treatment other than medications within the last year. Furthermore, the clinical documentation does support that the injured worker is clinically stable. Therefore, the need for an additional evaluation is not supported in this clinical situation. As such, the requested chronic pain clinic evaluation is not medically necessary or appropriate.