

Case Number:	CM14-0168358		
Date Assigned:	10/16/2014	Date of Injury:	07/26/2013
Decision Date:	11/28/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/13/2014

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 Preventive Medicine, has a subspecialty 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:

This injured worker is a 65 year old employee with date of injury of 07/26/2013. Medical records indicate the injured worker is undergoing treatment for myofascial pain, knee pain, right shoulder pain and depression. Subjective complaints include right arm and shoulder pain, low back pain. Objective findings include limited range of motion in right ankle. She continues to have an abnormal gait. Treatment has consisted of braces/casts, physical therapy, occupational therapy, cold packs, knee immobilizer, DME, HELP program, gait training, massage, home exercise program, surgery, acupuncture, and aquatic therapy. Medications include: Metoprolol, Lipitor, Lisinopril, ASA and Tylenol. The utilization review determination was rendered on 09/22/2014 recommending non-certification of HELP [REDACTED] Four Months.

IMR ISSUES, DECISIONS AND RATIONALES

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

HELP [REDACTED] Four Months: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Chronic Pain Programs

Decision rationale: MTUS states, "Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed." ODG states concerning chronic pain programs "(e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function." Treating physician has documented adequate and thorough evaluation, including baseline functional testing, multiple previous methods of treating chronic pain have been unsuccessful, the injured worker has had significant loss of ability to function independently resulting from pain, it is noted that the injured worker is not a candidate for surgery, it has been documented that the injured worker is motivated to change, negative predictors have been addressed, it is noted that the injured worker has developed anxiety and depression, along with sleep disturbances, the injured worker is not diagnosed with a personality disorder and the injured worker has continued to take recommended pain medications without improvement of symptoms. The injured worker has showed improvement in function and ability while participating in the functional restorative program. As such, the request for HELP [REDACTED] Four Months is medically necessary.