

Case Number:	CM14-0033899		
Date Assigned:	09/12/2014	Date of Injury:	03/02/2012
Decision Date:	10/06/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/18/2014

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 Family Medicine and is licensed to practice in Ohio. 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 31-year-old female whose date of injury was March 2 of 2012 whereby she slipped in the kitchen stepping into a drain and falling on her right ankle. Her diagnoses include right ankle sprain, degenerative disc disease of the lumbar spine, left-sided lumbar radiculitis, sacroiliitis bilaterally, and depression. Her primary complaints have been that of severe low back pain radiating into the left lower extremity and depression. She has been treated conservatively with pain medication, chiropractic care, physical therapy, acupuncture, sacroiliac injections, bilateral piriformis injections, and epidural steroid injections. Because of her failure to respond to conservative measures, she was referred to a functional restoration program. It appears that her first visit was 2-28-2014. At that time, it was documented that she could lift 3 pounds floor to waist, 3 pounds waist to shoulder, she could carry 4 pounds and neither hand for 20 feet, and 5 pounds with both hands for 20 feet she could push 10 pounds for 50 feet a rolling cart. A walk on the treadmill was not attempted because of antalgic gait but the injured worker stated she could walk 10-15 minutes. A note from 3-7-2014 suggested that she had completed three weeks of a functional restoration program. It was noted that she had a 45% improvement in anxiety and depression with improvements in strength and conditioning specifically she could not lift 5 pounds floor to waist and waist to shoulder, could carry 4 pounds and neither hand for 20 feet and 7 pounds with both hands 20 feet and was able to emulate 11 minutes at 1.5 mph on the treadmill. There is a request from 3-18-2014 for 4 additional weeks of a functional restoration program at 27 hours per week equaling 108 additional hours. There is also request from that date for a comprehensive metabolic profile, magnesium level, and vitamin D level to assess for a secondary cause of muscle spasms. Her physical exam is revealed tenderness in the paraspinal muscles in the lumbar regions, diminished lumbar range of motion, and diminished sensation to the left lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional functional restoration program 27 hr/wk x 4 wk=108 hr to be done at SFFRP:
Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain, Functional Restoration Programs.

Decision rationale: Criteria for the general use of multidisciplinary pain management programs (Functional restoration programs) and may be considered medically necessary when: (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore pre-injury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (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. (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) An adequate and thorough multidisciplinary evaluation has been made, medical and psychiatric. (4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided. (5) If there is a concern for substance abuse, a trial period may be utilized. (6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed. (7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications. (8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed. (9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as

there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population. (10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis. Total treatment duration should generally not exceed 4 weeks (20 full-days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. (Sanders, 2005) If treatment duration in excess of 4 weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed). In this instance, while there is some subjective evidence of psychological gain as of 3/7/2014, but there had been negligible gain functionally and the physical exam did not reflect an improved functional status. At the time of this request, 3-18-2014, the injured worker had completed 3 weeks of FRP. Yet, an additional 4 weeks of FRP was requested at that time. A clear rationale for the request for an additional 4 weeks of FRP, as opposed to an extension of up to the 4 week mark, was not clearly provided. Hence, additional functional restoration program 27 hr. /wk. x 4 wk. =108 hr. to be done at SFFRP, retroactive to 3-18-2014, was not medically necessary.

Comprehensive metabolic panel, Vitamin D, Magnesium: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

Decision rationale: The above referenced guidelines suggest that laboratory analysis has no role in identifying or defining low back pathology with respect to lumbosacral strain, disc protrusion, cauda equina syndrome, spinal stenosis, or post laminectomy syndrome. In this case, the treating physician wanted lab work to help identify the cause of muscle spasm, presumably specific to the low back in this instance. There was no mention of generalized muscle spasm to suggest a systemic issue thereby calling for the use of broader guidelines with regard to muscle spasms in general. Therefore, a comprehensive metabolic panel, vitamin D, magnesium level was medically unnecessary.