

Case Number:	CM14-0040054		
Date Assigned:	06/27/2014	Date of Injury:	08/04/2010
Decision Date:	08/20/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	04/04/2014

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 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 is a 41-year-old male patient with an 8/4/10 date of injury. He injured himself when pushing a patient up a ramp and developed low back pain. A progress report dated on 6/27/14 indicated that the patient complained of lower back pain and right shoulder pain. Physical exam revealed that the patient had an antalgic and slow gait, restricted range of motion in the cervical and lumbar spines. There was spasm and tenderness on palpation over the paravertebral muscles in the lumbar spine. Lumbar facet loading was positive on both sides. Shoulders physical exam revealed tenderness in the biceps groove and sub deltoid bursa. There was limited range of motion in the hips. He was diagnosed with cervical radiculopathy, Post cervical lam syndrome, Lumbar facet syndrome, Low back pain, Shoulder pain, and Elbow pain. Treatment to date: medication management, cervical and lumbar epidural steroid injections, TENS unit, and lumbar medial branch blockade on 10/30/13. There is documentation of a previous 4/4/14 adverse determination. Functional Restoration Program, based on the fact that there was no documentation supporting satisfactory criteria to approve such a program. This request is not medically necessary, Transportation is not medically necessary, because there was no indication that the patient was not able to transport himself. There was no documentation in regards to the fact that the patient had intolerance of oral voltaren therefore, is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 31-32.

Decision rationale: The Expert Reviewer's decision rationale:CA MTUS Chronic Pain Medical Treatment Guidelines criteria for functional restoration program participation include an adequate and thorough evaluation; previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; a significant loss of ability to function independently; that the patient is not a candidate where surgery or other treatments would clearly be warranted; that the patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; and that negative predictors of success above have been addressed. The patient presented with pain in his lower back and right shoulder. There was documentation that the patient has received adequate treatment, and underwent all possible diagnostic studies. However, it was not clear why this patient needs to participate in functional restoration program. In addition, there was no evidence of unsuccessful treatment or inability to have clinical improvement. In addition, it is unclear that the patient is motivated to return to work and is not a surgical candidate. In addition, a psychological report dated 2/14/14 recommends that the patient attend a coping skills group, start an antidepressant, and consider physical therapy, but the patient defers the group therapy. It is unclear why the patient is deferring the group therapy and if he is truly motivated to return to work and if all psychosocial factors have not been addressed. Therefore, the request for Functional Restoration Program is not medically necessary.

Transportation to and from Functional Restoration Program: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Back (Acute & Chronic), Transportation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Knee Chapter).

Decision rationale: The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG) (Knee Chapter).The Expert Reviewer's decision rationale:CA MTUS does not address this issue. Official Disability Guidelines states that transportation to and from medical appointments is recommended if medically-necessary. The patient presented with the pain in his lower back and right shoulder. He had analgesic and slow gait. However, there was no indication that the patient needed help for transportation. Therefore the request for transportation to and from functional restoration program is not medically necessary.

Voltaren Gel 1% QTY: 3.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: The Expert Reviewer's decision rationale:CA MTUS states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); and has not been evaluated for treatment of the spine, hip or shoulder. The patient presented with the pain in his lower back and right shoulder. However, there was no indication that the patient was not able to tolerate oral Nonsteroidal anti-inflammatory drugs. In addition, guidelines do not support topical Voltaren Gel for spine and shoulder. Therefore, the request for Voltaren Gel 1% QTY: 3.00 is not medically necessary.