MAXIMUS Federal Services

Case Number:	CM14-0049991		
Date Assigned:	07/07/2014	Date of Injury:	01/02/2012
Decision Date:	09/15/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	04/17/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 39-year-old female who has submitted a claim for chronic pain associated with an industrial injury date of January 2, 2012. Medical records from 2014 were reviewed. The patient complained of shoulder and right-sided low back pain. Pain was rated 6/10. Patient has not been able to return to work according to HELP evaluation dated March 24, 2014. Physical examination showed an antalgic gait; decreased cervical lordosis; flattened thoracic kyphosis, and increased lumbar lordosis. There is significant myofascial spasm, right greater than left, in the following areas: moderate in the suboccipital area, moderate to severe in the cervical paraspinals, trapezius, and rhomboids, moderate on the thoracic paraspinals, moderate to severe in the lumbar paraspinals, and moderate to severe spasm in the right levator scapulae. Other significant findings included tenderness over the right greater trochanter, right sacroiliac joint, and right piriformis; and pertinent loss of extension at the lower back with bilateral facet tenderness. There was also limitation of motion of the cervical and lumbar spine, right shoulder, right wrist, bilateral hips, and bilateral dorsiflexion. The diagnoses were chronic right shoulder pain; cervicalgia; mild to moderate adhesive capsulitis, right upper extremity; chronic low back pain, right much greater than left; right lower extremity radiculopathy by symptomatology and physical exam; myofascial pain syndrome; pain disorder associated with both psychological and medical factors; depression without psychotic features, moderate; sleep disorder; deconditioning; migraine by history; and history of rheumatoid arthritis. The patient underwent HELP program evaluation and was recommended to participate in the program for three to six weeks. It was stated that the patient is not a surgical candidate, and has failed previous treatment methods for chronic pain. Treatment to date has included oral and topical analgesics, muscle relaxants, physical therapy, SI joint injection, home exercise program, acupuncture, heat/cold modalities,

trigger point injections, and lumbar selective nerve root block. Utilization review from April 14, 2014 denied the request for HELP program 90 hours. The reason for the denial was not available.

IMR ISSUES, DECISIONS AND RATIONALES

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

HELP Program 90 hours: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines Work loss Data Institute, LLC Corpus Christi TX; www.odg.twc.com; Section; Pain (Chronic) (updated 03/27/2014).

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

Decision rationale: As stated on pages 31-32 of the California MTUS Chronic Pain Medical Treatment Guidelines, functional restoration program participation may be considered medically necessary when all of the following criteria are met: an adequate and thorough evaluation including baseline functional testing; previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; there is significant loss of ability to function independently; the patient is not a candidate where surgery or other treatments would clearly be warranted; the patient exhibits motivation to change; and negative predictors of success have been addressed. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. In this case, HELP evaluation done on March 24, 2014 stated that the patient has failed management including physical therapy, acupuncture, home exercise program, injections and medications. However, there was no objective evidence to support this. Also, there was no objective evidence of significant loss of ability to function independently. The guideline requires that all criteria be met. Moreover, the guideline recommends a trial period not exceeding 2 weeks with documented subjective and objective gains. The guideline criteria were not met. There was no compelling rationale concerning the need for variance from the guideline. Therefore, the request for HELP Program 90 hours is not medically necessary.