

Case Number:	CM14-0055237		
Date Assigned:	07/07/2014	Date of Injury:	02/06/2013
Decision Date:	08/21/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	04/24/2014

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 Medicine and is licensed to practice in Texas & Oklahoma. 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 42-year-old male who reported an injury on 02/06/2013 due to a fall of approximately 24 feet. The injured worker reportedly sustained injury to his upper back, left elbow and lower back. The injured worker was treated conservatively with physical therapy, medications, injections and Functional Restoration Program. A Letter of Appeal dated 03/26/2014 documented that the injured worker was to participate in a 6 week Functional Restoration Program. It was noted in the first 4 weeks that the injured worker had made significant functional gains. The injured worker continued to have deficits that required further treatment. It was noted that the final 2 weeks of the program had goals to assist the injured worker with returning to gainful employment. Retrospective authorization of the final 2 weeks of the program is requested. The injured worker was evaluated on 03/31/2014. It was documented that the injured worker had a 20% increase in chronic low back pain with numbness and tingling in the bilateral lower extremities. It was noted that the injured worker was interested in pursuing vocational rehabilitation to return to work as soon as possible. A request was made for 8 sessions of a [REDACTED] Program to advance is core strengthening program.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 sessions of aftercare at [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation The Official Disability Duration Guidelines, Treatment in Workers Compensation, 2014 web based edition; web-based edition - http://www.dir.ca.gov/t8/ch4_5sb1a5_2.html, Clinical practice guidelines for chronic, non-malignant pain management syndrome patients II: and evidence-based approach. J. Back Musculoskeletal Rehabil 1999 Jan 1; 13: 47-58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Program (Functional Restoration Program) Page(s): 30.

Decision rationale: The requested 8 sessions of aftercare at [REDACTED] is not medically necessary or appropriate. The clinical documentation submitted for review indicates that the injured worker has already completed 6 weeks of a Functional Restoration Program. This is well beyond the recommended 4 week program. The injured worker should be well versed in a home exercise program and cognitive behavioral techniques to manage chronic pain. There are no factors to preclude further progress of the patient while participating in a self-directed, self-managed program. There are no exceptional factors to support extending treatment beyond guideline recommendations. As such, the requested 8 sessions of aftercare at [REDACTED] are not medically necessary or appropriate.