

Case Number:	CM14-0130890		
Date Assigned:	08/20/2014	Date of Injury:	10/08/2012
Decision Date:	04/10/2015	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/14/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 60 year old female with an industrial injury dated 10/08/2012. Her diagnoses include lumbar/lumbosacral disc degeneration, sacroiliitis not elsewhere classified, knee strain, and Pes Anserinus bursitis. No recent diagnostic testing was submitted or discussed. Previous treatments have included conservative measures, medications, acupuncture, and physical therapy. In a progress note dated 07/28/2014, the treating physician reports bilateral knee pain with the left greater than the right, and muscle spasms in the low back with radiation into the bilateral legs associated with numbness and tingling, and with a pain rating of 9/10. The objective examination revealed crepitus in both knees, tenderness to palpation in the left petrochanteric, palpated trigger point in the upper and lower trapezius, gluteus medius and lumbosacral region bilaterally, mild weakness in motor testing of the bilateral lower extremities, decreased sensation to light touch in the left leg, positive SI joint compression test, positive McMurray's and Patellar compression tests bilaterally, valgus instability on the left, and positive slump test. The treating physician is requesting evaluation for functional restoration program and interdisciplinary evaluation which were denied by the utilization review. On 08/13/2014, Utilization Review non-certified a request for evaluation for functional restoration program, noting that a previous request for a multidisciplinary evaluation to determine if a functional restoration program would be appropriate was authorized (05/28/2014), and lack of documentation as to why another request is being submitted or whether the first one was completed. The MTUS guidelines were cited. On 08/13/2014, Utilization Review non-certified a request for interdisciplinary evaluation, noting that a previous request for a multidisciplinary

evaluation to determine if a functional restoration program would be appropriate was authorized (05/28/2014), and lack of documentation as to why another request is being submitted or whether the first one was completed. The MTUS guidelines were cited. On 08/14/2014, the injured worker submitted an application for IMR for review of evaluation for functional restoration program and interdisciplinary evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Evaluation for functional restoration program: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Multidisciplinary pain management programs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 49.

Decision rationale: The patient presents with bilateral knee pain with the left greater than the right, and muscle spasms in the low back with radiation into the bilateral legs associated with numbness and tingling, and with a pain rating of 9/10. The request is for EVALUATION FOR FUNCTIONAL RESTORATION PROGRAM. The RFA provided is dated 05/21/14. The patient is medically disabled. The MTUS guidelines pg. 49 recommends functional restoration programs and indicate it may be considered medically necessary when all criteria are met including (1) adequate and thorough evaluation has been made (2) Previous methods of treating chronic pain have been unsuccessful (3) significant loss of ability to function independently resulting from the chronic pain; (4) not a candidate for surgery or other treatments would clearly be (5) The patient exhibits motivation to change (6) Negative predictors of success above have been addressed. In this case, the patient has persistent chronic pain for which MTUS supports functional restoration program. The request is for an evaluation to determine the patient's candidacy. The request IS medically necessary.

Interdisciplinary evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Multidisciplinary pain management programs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 49.

Decision rationale: The patient presents with bilateral knee pain with the left greater than the right, and muscle spasms in the low back with radiation into the bilateral legs associated with numbness and tingling, and with a pain rating of 9/10. The request is for interdisciplinary evaluation. The RFA provided is dated 05/21/14. The patient is medically disabled. The MTUS guidelines pg. 49 recommends functional restoration programs and indicate it may be considered medically necessary when all criteria are met including (1) adequate and thorough evaluation has been made (2) Previous methods of treating chronic pain have been unsuccessful (3) significant loss of ability to function independently resulting from the chronic pain; (4) not a candidate for surgery or other treatments would clearly be (5) The patient exhibits motivation to change (6) Negative predictors of success above have been addressed. In this case, the patient has persistent chronic pain for which MTUS supports functional restoration program.

The request is for an interdisciplinary evaluation but the request is duplicative. There is already a request for functional restoration program evaluation which typically involves multi-disciplinary evaluations. Therefore, the request IS NOT medically necessary.