

Case Number:	CM14-0167975		
Date Assigned:	10/15/2014	Date of Injury:	11/23/2004
Decision Date:	04/10/2015	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	10/13/2014

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, Pain Management

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 (IW) is a 47 year old male who sustained an industrial injury on 11/23/2004. He has reported ongoing low back pain, weakness in the legs, and low back pain radiating in to the right groin. Diagnoses include low back strain. Past medical history includes osteopenia, chronic pain, cigarette smoker, and depression. Treatment to date includes medications including Ambien for sleep Opana for moderate to severe chronic pain, and Percocet for mild to moderate pain. A progress note from the treating provider dated 08/22/2014 indicates the IW continues to complain of low back pain that radiates to the right groin and posterior leg. The pain disturbs his sleep and improves with medication. On examination he has progressive weakness in the bilateral lower extremities. The left lower extremity has a tremor, and his hip flexor strength is diminished significantly in the hip flexor strength and mildly diminished in the quads, gastrocnemius and tibia. There is decreased sensation greater on the left than right side in the left lower extremity. Lumbar range of motion is severely limited in all planes and he has mild lower extremity swelling bilaterally. His gait has significant antalgia and he uses a single point cane on the right to ambulate. Heel-toe walk is not possible and the left leg bears most of the weight. Diagnostics include a MRI lumbar spine (04/30/2014) that showed multilevel chronic-appearing compression fracture deformities, no evidence of acute bony abnormality and arterolsthesis offset associated with the fracture deformity at T12-L1 as well as posterior offset of the posterosuperior corner of the L4 at the L3-4 level. Also noted on the MRI was severe central canal stenosis at the L3-L4 level, hypertrophic and degenerative changes contributing to a multilevel mild neural foraminal narrowing most notable and moderate in degree at L3-L4.

Treatment plan included pain medication and a multidisciplinary pain management program. According to the Utilization review letter, a similar functional restoration was done in 2005 and there is lack of new hard clinical indications for need for an evaluation to enter a very extensive program at this time. On 09/19/2014 Utilization Review non-certified a request for Multidisciplinary Pain Management Evaluation. The MTUS-ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multidisciplinary Pain Management Evaluation.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines X 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 30-34 and 49 of 127.

Decision rationale: Regarding the request for a Multidisciplinary Pain Management Evaluation, California MTUS supports chronic pain programs/functional restoration programs when: Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; The patient has a significant loss of ability to function independently resulting from the chronic pain; The patient is not a candidate where surgery or other treatments would clearly be warranted; The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success above have been addressed. Within the medical information available for review, there is no statement indicating that other methods for treating the patient's pain have been unsuccessful, no statement indicating that the patient has lost the ability to function independently, and no statement indicating that there are no other treatment options available. Additionally, there is no discussion regarding motivation to change and negative predictors of success. Additionally, it appears that the patient may have been through a previous functional restoration program, and it is unclear why a repeat program would be needed. In the absence of clarity regarding the above issues, the currently requested Multidisciplinary Pain Management Evaluation is not medically necessary.