

Case Number:	CM15-0006688		
Date Assigned:	01/26/2015	Date of Injury:	01/08/2013
Decision Date:	03/17/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/12/2015

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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 67 year old male, who sustained an industrial injury to low back and bilateral knees after a fall on 1/8/13. He has reported back and knee pain. The diagnoses have included low back pain, degeneration of lumbosacral intervertebral disc, lumbar sprain, degeneration of lumbar intervertebral disc and osteoarthritis of the knee. Treatment to date has included medications, physical therapy, rest, chiropractic, Home Exercise Program (HEP) and pneumatic lumbar traction. He has declined injection therapy and wants non surgical alternative to return to work. Currently, the IW complains of stabbing, aching pain to lumbar area and bilateral knees with radiation of pain down the right lower extremity. The pain is constant and rated 7/10. There is numbness in the right lower extremity with lumbar arthralgia, lumbar muscle spasms, and lumbar and gluteal myalgia. He reports depression and anxiety. His standing balance is slightly unsteady and he is unable to engage in previous recreational activities. He requires assistance with activities of daily living (ADL's), shopping and housekeeping. He is out of work because it involves heavy lifting. The physical exam revealed decreased gait, decreased lumbar lordosis, protracted shoulders and forward head position, tenderness of the gluteus and minimal paraspinal tenderness. There was decreased light touch over the right lateral thigh and diminished reflexes. His functional activities are limited by low back and right knee pain. On 12/18/2014 Utilization Review non-certified a request for 1 FUNCTIONAL RESTORATION PROGRAM LUMBAR SPINE FOR SUBMITTED DIAGNOSIS OF LUMBAR SPRAIN/STRAIN AS AN OUTPATIENT.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 FUNCTIONAL RESTORATION PROGRAM LUMBAR SPINE FOR SUBMITTED DIAGNOSIS OF LUMBAR SPRAIN/STRAIN AS AN OUTPATIENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25, 30-34.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The medical records provided for review do not indicate a medical necessity for 1 FUNCTIONAL RESTORATION PROGRAM LUMBAR SPINE FOR SUBMITTED DIAGNOSIS OF LUMBAR SPRAIN/STRAIN AS AN OUTPATIENT. Based on the report from the Utilization reviewer, the record submitted indicate the injured worker received treatment for the neck, but there was no documentation of conservative treatment rendered to the back. Also, the Utilization reviewer stated the request for additional medical records received no attention. Consequently, the requested treatment is not medically necessary and appropriate since the MTUS states as follows: "Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26MTUS (Effective July 18, 2009) Page 32 of 127(1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result insignificant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed."