

Case Number:	CM15-0169733		
Date Assigned:	09/10/2015	Date of Injury:	11/22/2011
Decision Date:	10/14/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	08/28/2015

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: 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 35 year old male with an industrial injury dated 11-22-2011. A review of the medical records indicates that the injured worker is undergoing treatment for lumbosacral spondylosis without myelopathy, sacroiliitis not elsewhere classified, lumbar disc displacement without myelopathy, myalgia and myositis not otherwise specified and sleep disturbance. Treatment consisted of diagnostic studies, prescribed medications, injection therapy and periodic follow up visits. In a progress note dated 07-31-2015, the injured worker reported ongoing low back and left lower extremity pain. The injured worker reported increased pain with increased activity and lifting of objects and partial relief by use of analgesic medications and injection therapy. Objective findings (07-23-2015) revealed left side low back pain and some left lower extremity tingling with bilateral foot numbness. Objective findings (07-31-2015) revealed no overt signs of intoxication or sedation. Gait and movements were noted to be within baseline of his level of functioning. The treating physician prescribed services for pain management consultation and treatment evaluation and FRP (Functional Restoration Program), now under review. Utilization Review determination on 08-19-2015, non-certified the request for pain management consultation and treatment evaluation and FRP (Functional Restoration Program).

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management consultation and treatment evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, page 112.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Prevention, General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment, Cornerstones of Disability Prevention and Management.

Decision rationale: This patient sustained a low back injury in November 2011 and continues to treat for chronic pain. Symptoms are stable without any new trauma and the patient is tolerating conservative treatments without escalation of medication use or clinically red-flag findings on examination. There is no change or report of acute flare. If a patient fails to functionally improve as expected with treatment, the patient's condition should be reassessed by consultation in order to identify incorrect or missed diagnoses; however, this is not the case; the patient remains stable with continued chronic pain symptoms on same unchanged medication profile and medical necessity for pain management consultation has not been established. There are no clinical findings or treatment plan suggestive for any interventional pain procedure. The Pain management consultation and treatment evaluation is not medically necessary and appropriate.

FRP (Functional Restoration Program): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Chronic pain programs (functional restoration programs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

Decision rationale: It appears the patient has not exhausted any conservative treatment trial and continues to treat. It is unclear why the patient requires a Functional Restoration Program evaluation at this time. The clinical exam findings remain unchanged and there is no documentation of limiting ADL functions or significant loss of ability to function independently resulting from the chronic pain. Submitted reports have not specifically identified neurological and functional deficits amendable to a FRP with motivation for return to work status. Per MTUS Chronic Pain Treatment Guidelines, criteria are not met. At a minimum, there should be appropriate indications for multiple therapy modalities including behavioral/ psychological treatment, physical or occupational therapy, and at least one other rehabilitation-oriented discipline. Criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; A level of disability or dysfunction; No drug dependence or problematic or significant opioid usage; and a clinical problem for which a return to work can be anticipated upon completion of the services. There is no report of the above nor is there identified psychological or functional inability for objective gains and measurable improvement requiring a functional restoration evaluation. Medical indication and necessity have not been established. The FRP (Functional Restoration Program) is not medically necessary and appropriate.

