

Case Number:	CM15-0029864		
Date Assigned:	02/23/2015	Date of Injury:	01/20/2003
Decision Date:	04/08/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	02/18/2015

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:

This 68 year old male sustained a work related injury on 01/20/2003. According to a letter from the requesting provider, dated 01/21/2015, the provider noted that his practice accepts new workers' compensation patients only when authorized for the Comprehensive Multidiscipline Assessment needed to create a BioPsychoSocial Model treatment plan. There were no more notes from this provider. According to a progress note dated 01/22/2015, from a different provider, the injured worker complained of chronic middle and lower spinal pain with spasm. He continued to have chronic gastric upset secondary to the use of nonsteroidal anti-inflammatory medication. He also had a number of episodes of gingivitis secondary to the use of long-term medication and secondary osteoporosis. He reported occasional headaches. He continued to take Andro Gel secondary to hypogonadism produced by long-term opioid use. Diagnoses included nonallo lesion lumbar region, nonallo lesion sacral region, muscle spasm, disc disorder other unspecified lumbar, degenerative arthritis of spine, acute gastritis, hypogonadism and fatigue. On 02/10/2015, Utilization Review non-certified comprehensive multidiscipline assessment. According the Utilization Review physician, baseline functional testing had not been performed, previous methods of treating chronic pain have been unsuccessful, the injured worker demonstrated loss of ability to function independently from chronic pain, the injured worker was not a candidate for surgical treatment, the injured worker was motivated to change and an assessment of potential negative predictors of success has been completed. According to a noted dated 01/21/2015, the request appeared to be solely because it was required before worker's compensation patients could be seen. The requesting physician has

not even seen the injured worker. The injured worker had virtually no positive objective findings on any of the 3 submitted exams. CA MTUS Chronic Pain Medical Treatment Guidelines, pages 31-32 were referenced. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Comprehensive Multidisciplinary Assessment: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 31-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 30-32.

Decision rationale: This patient presents with mid and low back pain with spasm, headaches, and chronic gastrointestinal issues. The treater is requesting a comprehensive multidisciplinary assessment. The RFA from 01/23/2015 shows a request for comprehensive multidiscipline assessment. The patient's date of injury is from 01/20/2003 and he is currently permanent and stationary. The MTUS Guidelines page 30 to 32 recommends Functional Restoration Programs when all of the following criteria are met including: 1. Adequate and thorough evaluation has been made. 2. Previous methods of treating chronic pain had been unsuccessful. 3. Significant loss of the ability to function independently resulting from chronic pain. 4. Not a candidate for surgery or other treatments would clearly be warranted. 5. The patient exhibits motivation change. 6. Negative predictor of success above has been addressed. These negative predictors include evaluation for poor relationship with employer, work satisfaction, negative outlook in the future, etc. The report making the request was not made available. The 01/22/2015 report shows that the patient continues to complain of chronic middle and lower spinal pain and spasms. He continues to have chronic gastric upset secondary to NSAID use. The patient has had numerous episodes of gingivitis secondary to medication use and secondary osteoporosis. The MTUS guidelines support functional restoration program given that the patient must meet a specific criteria. To determine the patient's candidacy, a full evaluation is appropriate to obtain. Given the patient's chronic and persistent pain, a functional restoration program evaluation appears reasonable and consistent with the MTUS guidelines. The request is medically necessary.