

Case Number:	CM15-0061106		
Date Assigned:	04/07/2015	Date of Injury:	12/07/2012
Decision Date:	05/08/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	03/31/2015

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: Iowa

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 49 year old male, who sustained an industrial injury on 12/07/2012. Diagnoses include cervical muscle spasm, cervical radiculopathy, cervical sprain/strain, lumbar annular tear, lumbar disc protrusion, lumbar radiculopathy, lumbar sprain/strain, left knee sprain/strain and loss of sleep. Treatment to date has included diagnostics including magnetic resonance imaging (MRI), work restriction, injections, and medications. Per the Primary Treating Physician's Progress Report dated 1/20/2015, the injured worker reported cervical spine, lumbar spine and left knee pain. The cervical spine pain was described as dull and aching and was rated as 7/10 without medications and 6/10 with medications. The lumbar spine pain was described as dull and aching and was rated as 8/10 without medications and 7/10 with medications. The left knee pain was described as dull, aching pain and was rated as 7/10 without medications and 5/10 with medications. Physical examination revealed pain at the left forearm with grip strength testing. Examination of the lumbar spine revealed decreased painful range of motion and tenderness to palpation at the SI joints, and the lumbar paravertebral muscles had tenderness and spasm. There was tenderness to palpation of the anterior knee, with no swelling, bruising, atrophy or lesion. Examination of the cervical spine revealed decreased painful ranges of motion with tenderness to palpation and spasm of the bilateral trapezii and paravertebral muscles. The plan of care included medications, physical therapy, shockwave therapy an acupuncture. Authorization was requested for functional improvement measure, NIOSH testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO FUNCTIONAL IMPROVEMENT MEASURE, NIOSH TESTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Program, Functional Restoration Programs Page(s): 30-34, 49.

Decision rationale: This terminology for the request does not appear to be standard, but appears to refer to a functional restoration program, which will be evaluated. It is unclear what the "NIOSH testing" portion is referring to. MTUS states that functional restoration programs (FRPs) are recommended but appropriate inclusion criteria are still being established. MTUS states long-term evidence suggests that the benefit of these programs diminishes over time and treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. The medical documentation indicates that the patient has chronic pain, but there is little documentation to support the necessity of this request. Prior qualified medical evaluations have suggested several treatments, and the patient is currently undergoing several simultaneous treatments to include medications and injections. There is no documentation of a baseline assessment or that establishes clear subjective and objective gains from the program. The necessity of a restoration program and the role in the overall care plan is also unclear. Therefore, the retrospective request for functional improvement measure, NIOSH testing, is not medically necessary.