

Case Number:	CM14-0211086		
Date Assigned:	12/23/2014	Date of Injury:	03/07/2012
Decision Date:	03/06/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/16/2014

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:

This is a male patient with the date of injury of March 7, 2012. A utilization review determination dated November 18, 2014 recommends non-certification of paraffin bath for home use, four trigger point injections, SF evaluation, and functional restoration program. A progress note dated October 16, 2014 identifies subjective complaints of chronic back pain that radiates to both legs, continued gastric issues, continued difficulty sleeping, depressed mood, and daily urinary incontinence since injury. The physical examination reveals tender areas noted over the bilateral lower lumbar facet joints, back flexion 20-30%, extension limited, and extension with lateral rotation was painful. The diagnoses include lower back pain, upper/lower extremity pain, urinary incontinence, myofascial pain, major depression, and gastritis. The treatment plan recommends omeprazole, CBC, H pylori, guiac x3, replacement cane, discontinue NSAID, urology appointment on December 9, 2014, continue trial, continued cream, and follow up with psychiatrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Paraffin bath for home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 9.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter, Paraffin wax baths

Decision rationale: Regarding the request for paraffin wax bath, California MTUS does not address the issue. ODG cites that paraffin wax baths are recommended as an option for arthritic hands if used as an adjunct to a program of evidence-based conservative care (exercise). Within the documentation available for review, there is no documentation of arthritic hands and adjunctive treatment with exercise. In the absence of the above documentation, the currently requested paraffin wax bath is not medically necessary.

Four trigger point injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of trigger point injections Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Trigger Point Injections

Decision rationale: Regarding the request four trigger point injections, Chronic Pain Medical Treatment Guidelines support the use of trigger point injections after 3 months of conservative treatment provided trigger points are present on physical examination. ODG states that repeat trigger point injections may be indicated provided there is at least 50% pain relief with reduction in medication use and objective functional improvement for 6 weeks. Within the documentation available for review, there are no physical examination findings consistent with trigger points, such as a twitch response as well as referred pain upon palpation. Additionally, there is no documentation of failed conservative treatment for 3 months. In the absence of such documentation, the requested four trigger point injections are not medically necessary.

SF evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127 Chapter 7

Decision rationale: Regarding the request for SF evaluation, California MTUS does not address this issue. ACOEM supports evaluation/consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit

from additional expertise. Within the documentation available for review, there is no information regarding what "SF evaluation" might be or what it is intended to address. As such, the currently requested SF evaluation is medically necessary.

Functional restoration program: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-34 and 49 of 127.

Decision rationale: Regarding the request for a functional restoration program, 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 documentation that an adequate and thorough evaluation has been made including baseline functional testing, 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. In the absence of clarity regarding the above issues, the currently requested functional restoration program is not medically necessary.

Back support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 523.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Low Back Chapter, Lumbar Supports

Decision rationale: Regarding the request for back support, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is

in the acute or subacute phase of treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested back support is not medically necessary.