

Case Number:	CM15-0018360		
Date Assigned:	02/06/2015	Date of Injury:	10/15/2002
Decision Date:	03/25/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/30/2015

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, 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:

The injured worker is a 40 year old male, who sustained an industrial injury on 10/15/02. He has reported low back pain related to a fall. The diagnoses have included lumbar strain, lumbar degenerative disc disease, myofascial pain. Treatment to date has included failed neurostimulator implant, back brace and oral medications. As of the PR2 dated 12/11/14, the injured worker reported 9/10 pain in the lower back. The treating physician noted limited range of motion of the lumbar spine. The treating physician requested a functional restoration program. On 1/7/15 Utilization Review non-certified a request for a functional restoration program. The utilization review physician cited the MTUS guidelines for functional restoration programs and chronic pain programs. On 1/30/15, the injured worker submitted an application for IMR for review of a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-32,49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs Page(s): 31.

Decision rationale: 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: (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 in significant 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. According to the documents available for review, the IW does not meet all 6 of the MTUS required criteria. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.