

Case Number:	CM15-0061319		
Date Assigned:	04/07/2015	Date of Injury:	07/04/2014
Decision Date:	05/11/2015	UR Denial Date:	03/17/2015
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: Indiana

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 69 year old male who sustained an industrial injury on 07/04/2014. Diagnoses include lumbago, lumbar spine musculoligamentous sprain/stain with radiculopathy, lumbar spine multilevel disc herniation per Magnetic Resonance Imaging, lower extremity peripheral neuropathy, right hip enchondroma, unsteady gait, bladder complains and right hip myalgias, arthralgia. Treatment to date has included diagnostic studies, medications, acupuncture, physical therapy, chiropractic sessions, back brace, TENS Unit, and Extracorporeal Shock Wave Therapy to the right hip. A physician progress note dated 02/25/2015 documents the injured worker has ongoing pain worse in the low back. He has complaints of numbness and tingling in the bilateral lower extremities. He has moderate right hip pain, and bladder problems. Treatment requested is for supervised functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Supervised functional restoration program: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Computerized ROM.

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

Decision rationale: MTUS states: "Long-term evidence suggests that the benefit of these programs diminishes over time" as well as "Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." and "Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved." Medical documentation provided did not provide sufficient information to warrant certification for a full program without an initial trial. Treatment notes do not clearly explain the rationale for a full treatment program without providing any interim evidence of progress. As such, the request is not medically necessary.