

Case Number:	CM14-0173578		
Date Assigned:	10/24/2014	Date of Injury:	08/16/2012
Decision Date:	11/25/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/21/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 44 year-old patient sustained an injury on 8/16/12 while employed by [REDACTED]. Request(s) under consideration include [REDACTED] Evaluation. Diagnoses include low back pain. Electrodiagnostic studies of the lower extremities were normal. Recent report dated 8/16/14 noted patient with complaints of headaches occurring 1x/month lasting 1-2 hours relieved with NSAIDs. Symptoms were not affecting ADLs and the patient was given 0% impairment rating. Low back pain was chronic, unable to perform heavy lifting. Exam showed lumbar spine with limited range; muscle spasm and guarding without neurological deficits in sensory and motor findings given 8% impairment; cervical spine was with full ROM and normal neurological findings in the upper extremities, given 0% impairment. Future medical provision included anti-inflammatories analgesics noting patient was not a candidate for surgical interventions or epidural injections with patient deemed as P&S. Medication lists Ibuprofen taken on an as-needed basis. The request(s) for [REDACTED] Evaluation was non-certified on 9/30/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for The General Use of Multidisciplinary Pain Management.

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

Decision rationale: This 44 year-old patient sustained an injury on 8/16/12 while employed by [REDACTED]. Request(s) under consideration include [REDACTED] Evaluation. Diagnoses include low back pain. Electrodiagnostic studies of the lower extremities were normal. Recent report dated 8/16/14 noted patient with complaints of headaches occurring 1x/month lasting 1-2 hours relieved with NSAIDs. Symptoms were not affecting ADLs and the patient was given 0% impairment rating. Low back pain was chronic, unable to perform heavy lifting. Exam showed lumbar spine with limited range; muscle spasm and guarding without neurological deficits in sensory and motor findings given 8% impairment; cervical spine was with full ROM and normal neurological findings in the upper extremities, given 0% impairment. Future medical provision included anti-inflammatories analgesics noting patient was not a candidate for surgical interventions or epidural injections with patient deemed as P&S. Medication lists Ibuprofen taken on an as-needed basis. The request(s) for [REDACTED] Evaluation was non-certified on 9/30/14. Guidelines criteria for a functional restoration program requires at a minimum, appropriate indications for multiple therapy modalities including behavioral/psychological treatment, physical or occupational therapy, and at least one other rehabilitation oriented discipline. Criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; A level of disability or dysfunction; No drug dependence or problematic or significant opioid usage; and A clinical problem for which a return to work can be anticipated upon completion of the services. It does not appear the patient has met the criteria for a functional restoration program. The patient continues treating with chronic symptoms; however, in stable condition taking Ibruprofen as needed with good efficacy, has minimal dosing and intake of NSAID with relief of symptoms to allow her to function. Submitted reports have not adequately demonstrated any specific limitations in ADLs, sleep deprivation, psychological issues, or significant pain complaints. Additionally, the patient has not demonstrated functional improvement from previous therapy received and has been deemed P&S for this chronic 2012 injury. Medical necessity and criteria to support for a multidisciplinary evaluation has not been established. The [REDACTED] Evaluation is not medically necessary and appropriate.