

Case Number:	CM13-0006390		
Date Assigned:	12/13/2013	Date of Injury:	03/04/2004
Decision Date:	01/23/2014	UR Denial Date:	07/16/2013
Priority:	Standard	Application Received:	08/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 physician 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:

The injured worker is a 60-year-old male with a date of injury of May 5, 2003 through April 1, 2004. The mechanism of injury is cumulative trauma. The injured worker is diagnosed with degenerative joint disease of the knees, status post arthroscopy of the right knee and large tear of the meniscus in the left knee. The patient also has a history of low back surgery in March 2007. This patient has complaints of depressive symptoms and was referred to cognitive behavioral therapy in April 2013. A recent program note on date of service 10/2/2013 indicates that the patient's urine drug screen is consistent. The patient complains of bilateral knee, shoulder, and back pain and is taking Norco and Lyrica. The patient continues to endorse symptoms of depression, and has been unable to exercise. His low back pain includes cramps which feel like an electric shock and radiates to the testicles and right lower extremity. He has tried multiple conservative therapies including Pennsaid gel, Lyrica, Norco, cortisone injection to the right shoulder, physical therapy, and weight loss attempts. A utilization review performed on date of service 10/1/2013 concluded that a multidisciplinary evaluation is medically necessary. However, 20 sessions were deemed not medically necessary with the reasoning that "it is premature to comment on the need for any days in the program."

IMR ISSUES, DECISIONS AND RATIONALES

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

Multidisciplinary Pain Program #20 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 31-33.

Decision rationale: "Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical therapy & occupational therapy (including an active exercise component as opposed to passive modalities). While recommended, the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) Unfortunately, being a claimant may be a predictor of poor long-term outcomes. (Robinson, 2004) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. The most commonly referenced programs have been defined in the following general ways (Stanos, 2006): (1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs: (a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus) (b) Multidisciplinary pain clinics (c) Pain clinics (d) Modality-oriented clinics (2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs. Types of treatment: Components suggested for interdisciplinary care