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| Case Number: | CM13-0020868 | | |
| Date Assigned: | 10/11/2013 | Date of Injury: | 02/01/2008 |
| Decision Date: | 01/31/2014 | UR Denial Date: | 08/21/2013 |
| Priority: | Standard | Application Received: | 09/06/2013 |

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 Pain Management, has a subspecialty in Disability Evaluation 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:

According to a limited and ineligible hand written note of [REDACTED], dated 9/18/2013, the patient is a 56 years male with date of injury of 02/01/1968, who presented for a follow-up to get medication refill. Details of the injury was not reported. Patient pain level was 4/10 with medications and 8/10 without medications. No New changes were reported. Patient was reported as stable. Awaiting for Median Branch Block L4, L5-S1. Examination Flexion 45 degrees and 30 degrees laterally. There was pain in middle of lumbar area-diffuse. Blood pressure was elevated. Diagnosis includes lower back Pain and L5-S1 fusion. Recommendation was to refill medication, referral for [REDACTED] program and patient to return to clinic in one month. At issues were whether the 1). Prospective request for referral to [REDACTED] program for functional restoration program (FRP) 2) Prospective request for I multidisciplinary evaluation for full or partial functional restoration program (FRP) 3) Prospective request for 1 medial branch blocks at L4/5 and L5/S1 4) Prospective request for 1 prescription of Baclofen 10mg #30 were medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 referral to [REDACTED] for functional restoration program: 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 Functional Restoration Page(s): 30-31.

Decision rationale: CA-MTUS (Effective July 18, 2009) page 30 to 31 of 127; section on chronic pain programs (functional restoration programs): 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) Also MTUS further explained that the Biopsychosocial model of chronic pain are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery, including the detailed "Criteria for use of multidisciplinary pain management programs" highlighted in blue. These treatment programs are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. However, records provided for review did not document any conditions that put them at risk of delayed recovery for the need of [REDACTED]; therefore, the prospective request for [REDACTED] is not medically necessary.

1 multidisciplinary evaluation for full or partial functional restoration program: 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 Page(s): 31-32.

Decision rationale: 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. Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a concurrent basis. Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. Based on the medical records reviewed, there is no evidence that a baseline functional testing have been performed as a reference, before referral to a Multi-Disciplinary Pain Management program for functional restoration program, therefore the request for 1 multidisciplinary evaluation for full or partial functional restoration program is not medically necessary, according to the guideline since not all the criteria have been met.

1 medical branch block at L4/5 and L5/S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

Decision rationale: ODG-TWC Low Back Procedure Summary states that facet joint medial branch blocks are not recommended except as a diagnostic tool. There is minimal evidence for treatment. Guidelines also note that facet blocks should not be used for patients who may undergo surgery or had a previous procedure at the planned level of injection. In regards to a medial branch block, this patient is not a candidate. Guidelines do not recommend facet joint medial branch blocks except as a diagnostic tool. The patient did not meet guideline criteria for diagnostic blocks, as guidelines do not recommend diagnostic facet blocks for patients who had previous fusion procedure at the planned injection level. Review of documentation revealed that the patient was status post L5-S 1 decompression and fusion surgery. Based on the medical

records reviewed as well as the above guidelines, the request for bilateral diagnostic and therapeutic facet injections at L5-S1 level is not medically necessary.

Baclofen 10mg #30: 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 Antispasmodics Page(s): 64.

Decision rationale: According to Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009), page 64, section on Muscle Relaxants (For Pain). Baclofen (Lioresal, generic available): The mechanism of action is blockade of the pre- and post-synaptic GABAB receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain (trigeminal neuralgia, non-FDA approved). (ICSI, 2007) Side Effects: Sedation, dizziness, weakness, hypotension, nausea, respiratory depression and constipation. This drug should not be discontinued abruptly (withdrawal includes the risk of hallucinations and seizures). Use with caution in patients with renal and liver impairment. Dosing: Oral: 5 mg three times a day. Upward titration can be made every 3 days up to a maximum dose of 80 mg a day. (See, 2008). Therefore the request for Baclofen 10mg #30 is not medically necessary based on the above guidelines recommendation.