

Case Number:	CM14-0152792		
Date Assigned:	09/30/2014	Date of Injury:	08/27/2012
Decision Date:	12/22/2014	UR Denial Date:	08/18/2014
Priority:	Standard	Application Received:	09/15/2014

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 Family 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 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 is a male who suffered an industrial related injury on 8/27/12. The treating physician's report dated 1/21/14 noted the injured worker complained of constant pain to his mid back radiating along the ribs with associated neck stiffness and headaches. The patient also had pain radiating from his back to his bilateral lower extremities. MRI results included T9-10 central disc protrusion without stenosis and C3-4 left sided foraminal stenosis was suspected. A lumbar spine MRI done on 9/18/12 showed multilevel degenerative disease of the lumbar spine, moderate to severe central canal stenosis at L2-3, L3-4, L4-5, and L5-S1 with possible impingement of traversing L5 nerve root on the left side. Moderate to severe neural foraminal narrowing on the left side at L4-5 and bilaterally at L5-S1 with possible impingement of exiting L5 nerve roots bilaterally at L5-S1 was noted. Multiple level disc bulges were noted at L1-S1. Electromyogram/nerve conduction study results showed lumbosacral radiculopathy with or without plexopathy at bilateral L5 root levels, left more than right with associated axonal loss. Possible left S1 radiculopathy was noted. The diagnoses included thoracolumbar sprain/strain, myofascial pain, lumbosacral sprain/strain with bilateral radiculopathy at L5 and S1, and cervical sprain/strain. The injured worker received a bilateral transforaminal epidural steroid injection at L4-5 on 2/10/14 with improvement noted. The treating physician's report dated 8/5/14 noted the injured worker continued to take Gabapentin, Tylenol with Codeine, and Nabumetone with some pain relief. The disability status was permanent and stationary. On 8/18/14 the utilization review (UR) physician denied the request for a functional restoration program evaluation. The UR physician noted there was no evidence or implication by history or exam of a significant loss of ability to function independently resulting from chronic pain there for the request is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional restoration program evaluation 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Multidisciplinary pain management programs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 30-33.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Functional Restoration Programs, page 30-33. The Expert Reviewer's decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Chronic Pain Programs including Functional Restoration Programs. These guidelines state that such programs are 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. While described as "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. 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. Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education. Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high

levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. 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. 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. In this case there is insufficient information in the medical records that indicate the patient meets each of the six MTUS criteria for enrollment in a functional restoration program. There is insufficient information that the patient has undergone baseline functional testing. There is insufficient information that there is an absence of other options. There is insufficient information that the patient has a significant loss of ability to function independently. Finally, there is insufficient information that negative predictors of success have been addressed. For all of these reasons a Functional Restoration Program is not considered as medically necessary.