MAXIMUS Federal Services

Case Number:	CM14-0070100		
Date Assigned:	07/14/2014	Date of Injury:	10/15/2013
Decision Date:	08/21/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	05/15/2014

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 Occupational 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:

The claimant was injured on 10/15/13 when he slipped and fell; a multidisciplinary evaluation is now under review. He landed on his buttocks and his lower back and bellybutton were painful. He saw a physician and was diagnosed with a back contusion. He complained of pain, numbness, and spasm. He had constant pain. He had minimal tenderness of the low back and no focal neurologic deficits. His gait was normal with no evidence of antalgia. X-rays showed a possible transverse fracture at L2, and he was sent to the ER for a CT scan. It showed no fractures. He reported improvement when he was seen on 10/30/13 but still had pain. He had good range of motion. Physical therapy (PT) was ordered. On 11/27/13, he was seen again. He had the same constant pain at level 6/10. He still had similar findings with tenderness but no evidence of antalgia or neurologic deficits. Exam was negative for hernias. PT was not helping much and he had 4 sessions left. MRI of the lumbar and thoracic spine was ordered. On 12/11/13, his pain was 3/10 but it was higher when he got up in the morning. He still had midline tenderness but no neurologic deficits and no antalgia. He was cleared to return to modified duty. MRI of the thoracic spine dated 12/23/13 was normal. On 01/03/14, he was seen again. He had similar findings. MRI of the lumbar spine showed a mild broad-based left lateral disc bulge abutting the left L3 nerve root at level L3-4. Epidural steroid injection (ESI) was recommended, and he was to continue his therapy. On 01/21/14, he had not improved. He still had pain with pressure and stabbing. He was waiting for PT and a physiatry consultation. On 01/28/14, he reported returning to full duty the day before. On 02/05/14, he saw another doctor and reported that his symptoms were worsening, but they improved with medications. He completed 6-8 total PT sessions. There was no focal loss of sensation and no weakness, and his reflexes were intact. He had normal strength, tone, and bulk with normal lower extremity range of motion. He was diagnosed with a contusion and strain and displaced disc. No interventional

pain techniques were recommended. A consultation for a functional restoration program was recommended. On 02/26/14, he still had pain. He had no significant findings. He was to continue physical therapy. He had a multidisciplinary evaluation dated 04/07/14 that indicated that he had constant pressure and tingling-like pain and sensation in the low back and left buttock, radiating to the left leg, with weakness radiating to the upper back. He had 70% pain in the back and 30% in the left leg. Extensive conservative care had included passive modalities with minimal relief, heat with no relief, and 12 sessions of PT. He was doing home exercises with minimal relief. He had abdominal pain and muscle weakness. Gait and heel/toe walking were normal. There was limited range of motion of the lumbar spine with hypoesthesia. He still had pain and had not returned to work. Evaluation with a psychologist and physical therapy were recommended. This was an evaluation for a possible functional restoration program. On 04/07/14, he reported extensive conservative care with TENS, electrical stimulation and exercises with minimal relief, heat with no relief and 12 sessions of PT that he had failed due to increased pain and flare-up. He had a home exercise program and was stretching with minimal relief. He had not progressed with his activities of daily living (ADLs). He was moderately depressed. On 04/09/14, he stated that the pain is alleviated by cold compresses but it still was level 8/10 and constant.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multidisciplinary Evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 82.

Decision rationale: The history and documentation support the request for a multidisciplinary program evaluation in this case. The MTUS guidelines state functional restoration programs (FRPs) are recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Functional restoration programs, a type of treatment included in the category of interdisciplinary pain programs, were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic, disabling, occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time but still remains positive when participants are compared to cohorts that did not receive an intensive program. (Bendix, 1998) A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. (Guzman 2001) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension,

limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. (Airaksinen, 2006) There appears to be little scientific evidence for the effectiveness of multidisciplinary bio-psycho-social rehabilitation as compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. In this case, the claimant has experienced delayed recovery, with pain and reported dysfunction that appear to be out of proportion to his objective findings. He has reported moderate depression. In cases of delayed recovery such as this, a multidisciplinary evaluation of his physical and possibly psychological factors is supported as reasonable and appropriate. He may need to be instructed in coping skills to help him to become more functional again and self-manage his symptoms. In the case of delayed recovery, this type of program appears to be reasonable, and, in order to establish the goals of this type of program, an evaluation to determine his functional impairments, both psychological and physical, can be recommended.