

<b>Case Number:</b>	CM14-0203694		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	06/04/2007
<b>Decision Date:</b>	02/09/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 52 year old patient with date of injury of 06/04/2007. Medical records indicate the patient is undergoing treatment for lumbar disc displacement without myelopathy and cervical disc displacement without myelopathy. Subjective complaints include low back, neck, right shoulder pain and bilateral upper extremity pain; low back pain radiates down the posterior aspect of right leg to heel. Objective findings include normal gait, no swelling in any extremity and normal muscle tone in bilateral upper extremities. Lumbar MRI dated 11/04/2012 revealed early degenerative changes with small profile protrusions and annular fissures, given generous volume of the central canal there is no associated mass effect or impingement; however, chemical mediators of inflammation associated with fissuring may contribute to an acute presentation of pain. Cervical MRI dated 11/11/2010 reveal disc osteophyte complex formation at C5-C6 and C6 levels, more prominent on the right combined with uncovertebral joint hypertrophy to cause moderate to marked right neural foramen narrowing and mild narrowing of the central canal at the C5-C6 level; straightening of normal cervical lordosis and other lesser degenerative changes. Treatment has consisted of physical therapy, Lidocaine Ointment, Gabapentin and Levothyroxine. The utilization review determination was rendered on 11/14/2014 recommending non-certification of Functional restoration program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional restoration program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25, and 30 - 34.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Program, Detoxification, Functional Restoration Programs Page(s): 30-34, 42, 49.

**Decision rationale:** MTUS states "Long-term evidence suggests that the benefit of these programs diminishes over time", "Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." and "Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved." MTUS states, "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." ODG states concerning chronic pain programs "(e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function." While the treating physician does document the use of medications, physical therapy, and anti-depressants, the treating physician has not provided detailed documentation of chronic pain treatment trials and failures to meet all six MTUS criteria for a chronic pain management program. In addition, shoulder surgery was recommended by two specialist which would not meet MTUS guidelines at this time. As such, the request for Functional restoration program is not medically necessary.