

Case Number:	CM15-0007272		
Date Assigned:	01/28/2015	Date of Injury:	07/27/1998
Decision Date:	03/18/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/13/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 54 year old woman sustained an industrial injury on 7/27/1998. The mechanism of injury is not detailed. Current diagnoses include wrist pain, extremity pain, and spasm of muscle. Treatment has included oral medication and psychological treatment. Physician notes dated 10/16/2014 show increased pain levels, decreased activity level and poor sleep quality. The treatment plan states that she has been approved to see psychology for pain coping skills, has continued wrist and elbow pain, failed physical therapy, and will be referred to an orthopedic surgeon to determine if surgical intervention is appropriate. Notes from [REDACTED] dated 12/19/2014, state the worker meets patient selection criteria and would like to have her enrolled at the next available opening, on January 5, 2015. Physician notes dated 1/15/2015 state that the worker has been accepted into the functional restoration program and that is agreeable with the physician as well. There is a note that the orthopedic surgeon has deferred surgical intervention for conservative treatment in the past, however, it is unclear if that is from the recently approved evaluation. Orthopedic notes dated 2/3/2015 show recommendations for MRI scans of her bilateral hands and injections on the day of service to the bilateral cubital tunnels. On 12/31/2014, Utilization Review evaluated a prescription for ten initial sessions of a functional restoration program, that was submitted on 1/13/2015. The UR physician noted that a candidate for the requested treatment program must not be a candidate for surgery or other treatments. The worker has been approved for an orthopedic evaluation to determine if surgical intervention is an option. It is unclear if this has been completed. Further, opioid use, high levels of psychosocial distress, and the duration of pre-referral disability are

negative predictors of success for a functional restoration program. The MTUS, ACOEM Guidelines, (or ODG) was cited. The request was denied and subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ten (10) initial sessions of Functional Restoration Program: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 31-33.

Decision rationale: 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 bio-psychosocial 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 bio-psychosocial 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. 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. In this case, the patient has been approved for an orthopedic evaluation to determine if surgical intervention is an option. It is unclear if this has been completed. Furthermore, there is no recent documentation of the patient motivation to attend a functional restoration program. Therefore, the request for 10 initial sessions of Functional Restoration Program is not medically necessary.