

<b>Case Number:</b>	CM15-0106882		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	12/11/2013
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 injured worker is a 38 year old male who sustained a work related injury December 11, 2013. According to a primary treating physician's medical re-evaluation, dated April 20, 2015, the injured worker presented with complaints of on and off upper back pain, rated 5/10. The pain radiates to his right mid-back, low back and left arm. He experiences sever numbness in the left arm and pain described as hot and cold pain. There is persistent lower back pain, rated 5/10 with worsening radiation, numbness, and tingling down the left leg. He was recommended injections to the lower back by pain management but refused at this time. He also has on and off left eye pain, rated 5/10, which increases when exposed to light and bending down. He complains of stress, anxiety, insomnia, and mild headaches. Physical examination revealed; left eye- pupil is not centered and the iris is irregular, the 5 o'clock position has a blackened part. Diagnoses are cervical and lumbar spine sprain/strain with myospasm; upper extremity neuropathy; headaches; eye contusion; s/p left eye surgery; lumbar spine annular fissure, disc desiccation, 4.7mm disc protrusion at L4-5; cervical spine disc desiccation with multi- level protrusion. At issue, is the request for authorization for a Functional Restoration program and home exercise instruction.

### 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 Multidisciplinary pain programs Page(s): 31, 32.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration program Page(s): 49.

**Decision rationale:** The California chronic pain medical treatment guidelines section on functional restoration programs states: Recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see chronic 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 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 biopsychosocial rehabilitation 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. For general information, see chronic pain programs. While functional restoration programs are recommended per the California MTUS, the length of time is for 2 weeks unless there is documentation of demonstrated efficacy by subjective and objective gains. The request does not define an amount of time. This is in excess of the recommendations and thus is not medically necessary.

**Home exercise instructions 1x2 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines exercise Page(s): 46-47.

**Decision rationale:** The California MTUS section exercise states: Recommended. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient

evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime. (State, 2002) (Airaksinen, 2006) A recent study of the long term impact of aerobic exercise on musculoskeletal pain, in a prospective cohort of 866 healthy seniors followed for 14 years, found that exercise was associated with a substantial and significant reduction in pain even after adjusting for gender, baseline BMI and attrition, and despite the fact that fractures, a significant predictor of pain, were slightly more common among exercisers. (Bruce, 2005) A recent trial concluded that active physical treatment, cognitive-behavioral treatment, and the two combined each resulted in equally significant improvement, much better compared to no treatment. (The cognitive treatment focused on encouraging increased physical activity.) (Smeets, 2006) Progressive walking, simple strength training, and stretching improved functional status, key symptoms, and self-efficacy in patients with fibromyalgia. (Rooks, 2007) Physical conditioning in chronic pain patients can have immediate and long-term benefits, according to a low-quality study presented at the American Academy of Pain Medicine 24th Annual Meeting. (Burlison, 2008) Physical therapy in warm-water has been effective and highly recommended in persons with fibromyalgia. In this RCT, an aquatic exercise program including one-hour, supervised, water-based exercise sessions, three times per week for 8 months, was found to be cost-effective in terms of both health care costs and societal costs. (Gusi, 2008) An educational technique known as the Alexander technique, along with exercise, is effective for long-term relief of chronic low back pain, according to the results of a randomized trial reported in the BMJ. (Little, 2008) While exercise is recommended, home exercise instruction is not medically necessary and the request is not certified.