

Case Number:	CM15-0145013		
Date Assigned:	08/07/2015	Date of Injury:	09/04/1996
Decision Date:	09/08/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/27/2015

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: California
 Certification(s)/Specialty: Psychologist

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 65 year old male who sustained an industrial injury on 9-4-96, when lifting a heavy object. He developed "low back pain with radicular component right leg" and underwent surgery in August 1997. The surgery "failed" and he continued with back pain syndrome. He was followed by a pain specialist and underwent "numerous procedures" including facet blocks and epidural corticosteroid injections. In a neurological evaluation note dated 6-5-15, it explains the injured worker's medical history, stating "a long-standing several year history of progressive degenerative changes involving both hips with secondary pain". He developed avascular necrosis and underwent a total left hip replacement in July 2014. The record states that he developed "traumatic injury to the sciatic nerve" and "total left foot drop, loss of the left ankle jerk, and numbness top and bottom of left foot" with the surgery. The injured worker was admitted to in-patient rehab, however, one month later, he fell, causing dislocation of the new left hip. He underwent closed reduction under general anesthesia. The neurological consult dated 6-5-15 indicates that the injured worker continues to have "some pain" involving both hips and has not shown improvement. The injured worker indicated that he is unable to extend his toes or dorsiflex his ankle. He continues to have numbness of the left foot, but more on the top than the bottom. He reports that the numbness extends upward on the lateral aspect of the left leg towards the knee. He walks with the use of a short leg brace and a cane. His diagnoses include history of total left hip replacement July 26, 2014 and sciatic mononeuropathy secondary to the hip replacement. Treatment recommendations were for EMG with nerve conduction. On a follow-up pain management appointment also dated 6-5-15, the

injured worker indicated that his pain control is "much better". He continues to take the following medications: Zanaflex, Voltaren gel, Flector, Neurontin, Gabapentin, Methadone, and Percocet. He reported the pain rating as an "8". His diagnoses include low back pain, lumbar spine pain, status post lumbar laminectomy, radiculopathy of lumbar region, and lumbar degenerative disc disease. A document dated 6-8-15 from psychiatry indicates that there was a request for authorization for the injured worker to attend an intensive outpatient program, 4 days per week for 4 months, then be re-evaluated. However, there is no other documentation from the psychiatrist. On the request for authorization, the diagnosis which accompanies this request is Major Depressive Affective Disorder, recurrent.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intensive Outpatient Program four (4) times a week for sixteen (16) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2, Behavioral Interventions, chronic pain programs (functional restoration programs) page 30-33: see also Part 2, behavioral interventions, Functional restoration programs (FRPs) page 49.

Decision rationale: Citation Summary: A request was made for intensive outpatient program for times a week for 16 weeks. The MTUS guidelines does not address specifically this request however does discuss the issue in terms of chronic pain programs and functional restoration programs and the citation will be utilized to address this request. According to the MTUS guidelines pain treatment, functional restoration 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 returned to work. 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) and adequate and thorough evaluation has been made, including baseline 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 clinically significant 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 for surgery or other treatments would be clearly 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 affect this change; & (6) negative predictors of success have been addressed. As documented by subjective and objective gains. A request was made for intensive outpatient program 4 times a week for 16 weeks, the request was non- certified by utilization review was provided the following rationale for its decision: "psychological treatment is recommended for appropriately identified patients during treatment for chronic pain and they help identify and address specific concerns about pain and emphasize self-management. However, there is a lack of clarity as to what request entails, such as hours per

day, services to be rendered, and need for 6 weeks of this therapy. Therefore the recommendation is for non-certification." This IMR will address a request to overturn that decision. According to a June 8, 2015 letter, it is noted that: "it has also been requested that this patient be authorized to attend the good [REDACTED] 4 days a week for 4 months. At the end of the 4 months, he will be reevaluated for more time. This is not been addressed by the claims adjuster."The medical necessity of this request is not established due to several issues. 1st, according to the MTUS guidelines for functional restoration programs it is stated that "treatment does not suggest that for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." This request is excessive in that it is for duration of 16 weeks or 4 months just 8 times recommendations listed in the MTUS. This reason alone medical necessity of this request is not established excessive duration of treatment requested. However there are additional issues that need to be addressed. The patient would need to be evaluated properly. There is no evaluation for this treatment modality provided. Detailed information regarding prior psychological and functional restoration treatment program history participation would be needed as well the above-mentioned 6 criteria will also need to be addressed in the evaluation. This patient's prior treatment history is unknown and no details were provided whatsoever regarding what is received in the way of this treatment modality. For these reasons the medical necessity of this request is not been established adequately and therefore the utilization review decision is upheld. This is not to say that this patient is not need a intensive outpatient program for his industrial related injury as well as sequelae that resulted from recent surgical interventions, is saying that the request as written was insufficient in documented prior treatment history detail and excessive duration in order to establish the basis for the medical necessity of the treatment requested. The request IS NOT medically necessary.