

Case Number:	CM15-0148419		
Date Assigned:	08/11/2015	Date of Injury:	08/15/2012
Decision Date:	09/08/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	07/30/2015

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, Alabama, 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:

The injured worker is a 46-year-old female who sustained an industrial injury on 08-15-2012. The injured worker was diagnosed with cervicalgia, cervical radiculopathy, lumbago and bilateral carpal tunnel syndrome. The injured worker is status post cervical spine fusion in 2012 and revision C4-5 through C6-7 decompression without fusion in April 2013, left carpal tunnel release in February 2014 and right carpal tunnel release in April 2014. Treatment to date has included diagnostic testing with recent electrodiagnostic studies in March 2015, surgery, trigger point injections, radiofrequency ablation of the cervical spine, physical therapy, pain management and medications. According to the primary treating physician's progress report on March 18, 2015, the injured worker continues to experience bilateral hand and elbow pain with numbness and tingling of the bilateral forearms and fingers and neck pain worse on the right side than the left. Examination of the cervical spine noted limited range of motion with flexion at 10 degrees, bilateral lateral rotation and extension at 15 degrees each. Bilateral forearm and hand edema was documented. Examination of the elbows noted tenderness at the cubital tunnel with positive elbow flexion test and Tinel's at the cubital tunnel. Range of motion of the elbows noted full extension and flexion to 145 degrees with pain. There was tenderness at the extensor, flexor and pronator origin with severe tenderness and tightness over the dorsal and volar forearms. Wrist range of motion was documented as extension, flexion, pronation and supination at 80 degrees each with severe pain. The thumb and digits had full range of motion with pain and guarding. Motor strength was noted as 5 out of 5 with subjectively decreased sensation in all digits bilaterally. Current medications were listed as Opana and OxyContin. Treatment plan

consists of continuing with medication and the current request for a functional capacity evaluation (FCE) and functional restoration program (FRP).

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional capacity evaluation (FCE) with oasis: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, early intervention, Guidelines Assessing Red Flags and Indication for Immediate Referral Page(s): 32-33, 171.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: "Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach: (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernable indication of at risk status is lost time from work of 4 to 6 weeks". (Mayer 2003) There is no documentation that the patient's condition requires functional capacity evaluation. There is no strong scientific evidence that functional capacity evaluation predicts the patient's ability to perform his work. In addition, the provider should document that the patient reached her MMI. The requesting physician should provide a documentation supporting the medical necessity for this evaluation. The documentation should include the reasons, the specific goals and end point for Functional Capacity Evaluation. Therefore, the request for Functional Capacity Evaluation is not medically necessary.

Functional restoration program x 2 lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration program. Decision based on Non-MTUS Citation Official Disability Guidelines.

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. Unfortunately, being a claimant may be a predictor of poor long-term outcomes. (Robinson, 2004) These treatment modalities are based on the biopsychosocial 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 biopsychosocial rehabilitation compared with other rehabilitation facilities for neck, 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. Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pretreatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel, 2005) Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of Spine. (Buchner, 2007) See also Chronic

pain programs, early intervention; Chronic pain programs, intensity; Chronic pain programs, opioids; and 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. There is no clear evidence that the patient requires functional restoration program. The requesting physician did not provide a documentation supporting the medical necessity for a Functional Restoration Program. The documentation did not include the reasons, the specific goals and end point for using the expertise of a specialist for Functional Restoration Program. Therefore, the request for Functional restoration program x 2 lumbar spine is not medically necessary.