

Case Number:	CM15-0219185		
Date Assigned:	11/12/2015	Date of Injury:	06/06/2006
Decision Date:	12/31/2015	UR Denial Date:	10/23/2015
Priority:	Standard	Application Received:	11/06/2015

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: Texas, California
 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 55 year old male who sustained an industrial injury on 6-6-06. The injured worker reported back pain. A review of the medical records indicates that the injured worker is undergoing treatments for dysthymic disorder and post-laminectomy syndrome. Medical records dated 5-29-15 indicate pain rated at 8 out of 10. Provider documentation dated 10-2-15 noted the work status as temporary totally disabled. Treatment has included status post lumbar laminectomy (2007), status post lumbar fusion (2008), physical therapy, acupuncture treatment, transcutaneous electrical nerve stimulation unit, restoration treatment. The medication list include Trazodone, Suboxone, Lyrica, Valium, Baclofen since at least May of 2015, Restoril since at least May of 2015 and Methocarbamol since at least May of 2015. Medical records dated 10-2-15 indicate pain rated at 6 out of 10. Objective findings dated 10-2-15 were notable for lumbar spine with tenderness to spinous process at L3-S1 and negative straight leg raise test. The patient had poor mood, depression, excessive cigarette smoking and difficulty in sleeping. The original utilization review (10-23-15) denied a request for Functional Restoration program to include medical, physical therapy, occupational therapy and behavioral medicine. The patient sustained the injury when he dropped a manhole cover. Per the note dated 10/9/15 the patient had complaints of chronic back pain with radiation in left leg with numbness. Physical examination of the lumbar spine revealed limping gait, positive SLR at 85 degree, no tenderness on palpation, painless ROM and good strength and sensation. The patient had received an unspecified number of PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration program to include medical, physical therapy, occupational therapy and behavioral medicine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

Decision rationale: Per the cited guidelines: 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; (6) Negative predictors of success above have been addressed. The criteria for chronic pain management program have not been met as per records provided. The pain evaluation of this patient (e.g. pain diary) was also not well documented and submitted for review. Baseline functional testing that documents a significant loss of ability to function independently resulting from the chronic pain was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. A detailed response to previous conservative therapy was not specified in the records provided. In addition, per cited guideline: 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: (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) (7) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain. The patient has had depression and anxiety disorder. The patient has an increased duration of pre-referral disability time more than 2 years. There is conflicting evidence that chronic pain programs would provide return-to-work in this kind of patient. The medical necessity of the request for Functional Restoration program to include medical, physical therapy, occupational therapy is not medically necessary for this patient.