

<b>Case Number:</b>	CM15-0087962		
<b>Date Assigned:</b>	05/12/2015	<b>Date of Injury:</b>	02/04/2011
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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 48-year-old female who sustained an industrial injury on 02/04/2011. Current diagnoses include herniated lumbar disc with annular tear with radiculopathy to right lower extremity, chronic recurrent musculoligamentous sprain, cervical spine with headaches, chronic recurrent right shoulder tendinitis and bursitis, chronic recurrent left hip bursitis, and chronic anxiety. Previous treatments included medication management, lumbar epidural injection, left hip injection, and home exercises. Previous diagnostic studies include an MRI of the lower back on 02/10/2011, 06/07/2011, and 10/24/2012, and electro diagnostic study. Initial injuries occurred when the worker fell off a ladder sustaining multiple injuries. Report dated 02/27/2015 noted that the injured worker presented with complaints that included low back pain, numbness and tingling in both legs and right foot, neck pain, stiffness in the neck and low back, pain in left hip, right shoulder pain, and anxiety. Pain level was not included. Physical examination was positive for neck pain with palpation, sensory deficits in both upper extremities, pain over the superior nuchal ligaments bilaterally, pain in the right shoulder and bicipital groove and greater trochanteric region, range of motion in the left hip is painful and pain in the lateral aspect of the left hip, pain with palpation in the lower back, positive straight leg raises, sensory deficit in L4-S1 in the right lower extremity, sciatic notch pain on the right, positive Lasegue on the right, guarding in the low back, and decreased range of motion in the low back secondary to pain. It is noted that the injured worker does not want to undergo any lower back surgical options. The treatment plan included reviewed MRI results and AME ratings, issued medications, reviewed proper body mechanics, utilizing a heating pad at home, requires

vocational rehabilitation, may require occasional steroid injections in the left hip and additional low back epidural injections, home exercises and gym and indoor pool has been strongly recommended, and follow up in 8 weeks. Disputed treatments include vocational rehabilitation for the lumbar spine.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Vocational rehabilitation lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 127.

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

**Decision rationale:** According to MTUS, 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. 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. Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical treatment; (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education. 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.

(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 insignificant 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 documentation that the patient exhibits motivation to change, and is willing to forgo secondary gains, including return to work. Furthermore, there is no objective documentation that the patient failed previous methods for treating pain and has a significant loss of function. Therefore, the request for Vocational rehabilitation lumbar spine is not medically necessary.