

<b>Case Number:</b>	CM15-0236006		
<b>Date Assigned:</b>	12/11/2015	<b>Date of Injury:</b>	12/06/2012
<b>Decision Date:</b>	01/21/2016	<b>UR Denial Date:</b>	11/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2015

### 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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 56 year old male who sustained an industrial injury on 12-6-12. A review of the medical records indicates that the worker is undergoing treatment for status post re-do discectomy with foraminotomy and decompression at left L4-L5 and L5-S1 (11-5-14) with excellent leg pain relief, status post lumbar hemilaminectomy (11-27-13) (initial improvement and subsequent recurrence), degenerative disc disease L4-L5 and L5-S1 and lesser extent L3-L4, resolved radiculopathy and radiculitis post-operatively, residual low back pain and no deep venous thrombosis. Subjective complaints (10-28-15) include worsening pain rated at 6 out of 10. Objective findings of the lumbar spine (10-28-15) include pain to palpation, muscle spasms, limited range of motion, abnormal motor strength left and right, and abnormal straight leg raise and findings of the lumbar spine (7-20-15) include flexion 80% of normal, extension 80% of normal, and side to side bending 80% of normal left and right. Work status was noted as return to modified work with limitations-restrictions. Previous treatment includes spine surgery, physical therapy (about 3 months), acupuncture, chiropractic treatments, epidural injection (reported as temporarily helpful), anti-inflammatory medications, bracing, activity modifications, lumbar hemilaminectomy (11-27-13), and redo laminectomy left L4-L5 and L5-S1 (11-5-14). The treatment plan includes Norco 10-325 #120, physical therapy, water therapy, and functional restoration program. The requested treatment of interdisciplinary chronic pain evaluation (FRP) for 6 weeks was non-certified on 11-10-15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interdisciplinary chronic pain evaluation (FRP) for 6 weeks: Upheld**

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

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

**Decision rationale:** 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. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) 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) 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. Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that these gains are being made on a

concurrent basis. Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function. According to the documents available for review, the injured worker meets the aforementioned MTUS criteria for the use of FRP. However, the request for 6 weeks of initial treatment is in contrast to the guidelines which suggests 2 weeks of initial trial. Therefore at this time the requirements for treatment have not been met. Therefore the request is not medically necessary.