

Case Number:	CM14-0118358		
Date Assigned:	09/12/2014	Date of Injury:	09/12/1997
Decision Date:	10/07/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/25/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 55-year-old female patient who reported an industrial injury on 9/12/1997, over 17 years ago, attributed to the performance of his usual and customary job tasks. The patient is noted to have had bariatric surgery in 2007, lumbar fusion at L3-L4 and L4-L5 during 2009 and a lumbar epidural steroid injection during July 2013. The patient is been treated with physical therapy, activity modifications, aquatic therapy, interventional injections, pain management and medications. The MRI of the lumbar spine documented evidence of interval postsurgical findings of anterior posterior fusion at L3-L4 and L4-L5 with posterior hardware, decompression of the central canal and there is a solid anterior bony fusion with interbody graphs. There is no visualized nerve root compression at these postsurgical levels. At L2-L3 there is a 3-4 mm annular disc bulge and facet hypertrophy with moderate central canal narrowing, moderate right and mild left neural foraminal narrowing. Despite the prior bariatric surgery the patient was noted to have a BMI of 40. The patient complained of chronic low back pain radiating to the bilateral lower extremities. The patient reported having difficulty walking and is been using a single point cane. The objective findings on examination were tenderness to palpation lumbosacral junction; lumbar spine range of motion reduce; decreased hip strength; decreased left foot dorsiflexion strength; sensation decreased to light touch along the left lower extremity compared to the right lower extremity; deep tendon reflexes (DTRs) normal; straight leg raise (SLR) negative bilaterally. The patient was diagnosed with lumbosacral spondylosis and cervical disc displacement. The patient was not working. Patient was recommended to have an initial consultation for a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Initial Evaluation Functional Restoration Program (FRP): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 92; 127, Chronic Pain Treatment Guidelines functional restoration program Page(s): 30-32. Decision based on Non-MTUS Citation chapter 6 pain, suffering, and functional restoration pages 113-115; chronic pain chapter 8/8/2008 interdisciplinary pain rehabilitation programs Official Disability Guidelines (ODG) pain chapter-functional restoration programs; chronic pain programs

Decision rationale: The patient is currently being treated for a lower back pain; hip pain; and reported neck, and upper extremity pain subsequent to the reported industrial injury over 17 years ago. The patient is requested to receive a consultation for a FRP for chronic mechanical back pain, neck/upper extremity (UE), and hip pain 17 years after the date of injury (DOI). It is not clear why further conditioning and strengthening has not occurred with the previously provided sessions of physical therapy and the recommendations for a self-directed home exercise program. There is no demonstrated medical necessity for the requested functional restoration program, as a requesting provider has not documented the criteria recommended by the California MTUS. The request for authorization of a consultation for evaluation of the patient for a FRP is not supported with objective evidence to support the medical necessity of the request for consultation for the formal functional restoration program. The patient is currently assessed as not making additional progress with persistent pain; however, it is not clear that the patient is participating in a self-directed home exercise program in order to return to work. The patient is 19 months statute post (s/p) date of injury and is not demonstrated to have failed bona fide conservative care or participated in a self-directed home exercise program. There is objective evidence provided that the patient cannot be treated with the ongoing conservative treatment as provided without the intervention of a formalized FRP. There is no objective evidence that the FRP is medically necessary for the diagnosis of an unspecified pain issue, as the evaluation of the patient is not complete. There is no significant documented objective evidence provided that supports the medical necessity of the requested consultation for a FRP as a requirement before returning to modified work. The appropriate treatment has not been demonstrated to have failed. The patient has few objective findings on examination other than reported TTP and decreased range of motion (ROM). California MTUS, Chronic Pain Chapter, Pages 30-32: 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) The treatment provided to date from the date of injury has been outlined and demonstrated to be appropriate treatment for the diagnoses obtained. It is clear that the ongoing complaints by the patient are consistent with the documented objective findings on physical examination. The ACOEM Guidelines state: "If a patient fails to functionally improve as expected with treatment, the patient's condition should be reassessed in order to identify incorrect or missed diagnoses. Further treatment should be appropriate for the diagnosed conditions, and should not be performed simply because of continued reports of pain." The patient should be requested to have an evaluation by the multidisciplinary pain management program only after the appropriate treatment has been attempted and failed on an outpatient basis. If the patient is found suitable for admission based on the evidence-based guideline recommended criteria, a request could be made for the provision of a program of up to two weeks to allow for the demonstration of functional improvement with the provided treatment. The ACOEM Guidelines recommend that the patient have a "known etiology of the chronic pain syndrome or a specific condition which includes physical injury." The ACOEM Guidelines recommend: "Other appropriate medical and/or invasive care has been attempted and proved to be inadequate to restore functional status." The ACOEM Guidelines also recommend that the patient has appropriate rehabilitation potential (i.e., he or she is judged to be able to substantially benefit from the program.". Dr. Chen has not documented that the patient is motivated or willing to participate in the requested program or that he has demonstrated rehabilitation potential. The CA MTUS and the Official Disability Guidelines state: Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances: (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequela that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function. (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) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician

prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment. The treating physician has not demonstrated that "previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement." There is evidence of a chronic pain syndrome with a loss of function that meets three (3) of the criteria referenced above in Section 1a-g. There is no documented dependency on medical providers, deconditioning, withdrawal from social contact, or increasing psychological issues. There is no demonstrated medical necessity for the requested initial consultation for a functional restoration program.

