

<b>Case Number:</b>	CM14-0166226		
<b>Date Assigned:</b>	10/13/2014	<b>Date of Injury:</b>	12/02/2010
<b>Decision Date:</b>	11/13/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2014

### 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:

The patient is a 48 year-old man who was injured at work on 9/10/2012. The injury was primarily to his neck and back. He is requesting review of denial for enrollment in a Functional Restoration Program. Medical records corroborate ongoing care for his injuries. These records include his Primary Treating Physician's Progress Reports (PR-2s). His chronic diagnoses include the following: Myelopathy with Progressive Neurologic Dysfunction in the Left Lower Extremity; Radiculopathy Left Lower Extremity; Neck Pain; Multi-Level Disc Herniation's Cervical Spine; Low Back Pain; Multi-Level Disc Herniation's Lumbar Spine; TIA; Rule out Depression. Treatment has included the following medications: Cyclobenzaprine, Diclofenac, Omeprazole, Ondansetron, Tramadol, and Wellbutrin. He has also undergone a course of physical therapy, acupuncture, and Epidural Corticosteroid Injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Restoration Program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49, 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 30-32.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Chronic Pain Programs/Functional Restoration Programs. These guidelines state that such programs are "recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. " Further, there needs to be evidence that the patient is "motivated to improve and return to work, and meet the patient selection criteria outlined below. " 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. These negative predictors include the following:(a) a negative relationship with the employer/supervisor; (b) poor work adjustment and satisfaction; (c) a negative outlook about future employment; (d) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (e) involvement in financial disability disputes; (f) greater rates of smoking; (g) duration of pre-referral disability time; (h) prevalence of opioid use; and (i) pre-treatment levels of pain. 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. In this case, there is insufficient documentation as to the goals of a functional restoration program for this patient. There is insufficient documentation of baseline functional testing so follow-up with the same test can note functional improvement. The specific cause of the patient's underlying disability is unclear and therefore, it cannot be determined whether there is an absence of other options likely to result in significant clinical improvement. There is no evidence that the patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change. There is insufficient documentation in determining whether the described "negative predictors of success" have been identified and addressed. Finally, there is no evidence that total treatment duration has been considered as part of this request. Specifically, that a plan is proposed to include an assessment of efficacy within a 2 week timeframe. For these reasons, a Functional Restoration Program is not considered as medically necessary.