

<b>Case Number:</b>	CM14-0212551		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	04/15/2013
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

### 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. 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

### 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 42 year old patient with date of injury of 04/15/2013. Medical records indicate the patient is undergoing treatment for s/p L5-S1 fusion, L5-S1 disc injury s/p slip and fall. Subjective complaints include low back pain, physical therapy. Objective findings include alert and oriented x 3, intact strength noted in EHL, tibialis anterior, gastrocs and quads, well- healed surgical wounds, limited range of motion. X-ray of lumbosacral spine dated 09/25/2014 revealed postoperative changes L5-S1 with spacer and oblique screws in place, no sublaxation, mild lumbar levoscoliosis, right upper quadrant surgical clips, right hemipelvic surgical clip, T10 and T11 compression fracture. Treatment has consisted of surgical intervention, back brace, Furosemide, Spironolactone, Latulose, Oxycodone, Soma, Norco, Ambien and Lasix. The utilization review determination was rendered on 12/15/2014 recommending non-certification of Pain management treat and eval.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain management treat and eval:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM Practice Guidelines Chapter 7 Independent Medical Examinations and Consultations, page 127

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain program Page(s): 30-34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Chronic Pain Programs.

**Decision rationale:** MTUS states, "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." ODG states concerning chronic pain programs "(e) Development of psychosocial sequelae 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." While the treating physician does document the use of opioids and anti-depressants, the treating physician has not provided detailed documentation of chronic pain treatment trials and failures to meet all six MTUS criteria for a chronic pain management program. As such the request for Pain management treat and eval is not medically necessary.