

<b>Case Number:</b>	CM15-0012433		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	10/10/2014
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	12/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: 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:

The injured worker is a 52 year old female who sustained a cumulative work related injury to her neck on October 10, 2014. The injured worker was diagnosed with cervical sprain/strain, myospasm. X-Rays noted decreased disc level at C4-5 and mild hypertrophic changes of the lumbar spine. No further diagnostic studies were documented. Treatment modalities consist of conservative measures, chiropractic therapy times 14 sessions and physical therapy times 6 sessions. According to the primary treating physician's progress report on October 14, 2014, the injured worker continues to experience dull, achy neck pain radiating to the bilateral upper trapezius muscles; mid and lower back pain, bilateral shoulder, bilateral elbow and bilateral wrist pain. Her left wrist pain radiates to the 5th, 4th and 3rd digits with tingling and weakness and locking at the thumb. Current medications were not noted. Range of motion is diminished in all areas due to pain. The injured worker is on temporary total disability (TTD) and currently not working. The treating physician requested authorization for Pain Management Referral. On December 22, 2014 the Utilization Review denied certification for Pain Management Referral. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines (ODG).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain Management Referral: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain management

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain program Page(s): 30-34. Decision based on Non-MTUS Citation 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. The medical documentation provided does not document the use of opioids and/or 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 Referral is not medically necessary.