

<b>Case Number:</b>	CM15-0015572		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	11/09/2012
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 following clinical case summary was developed based on a review of the case file, including all medical records: The injured worker is a 26 year old female, who sustained an industrial injury on November 9, 2012. She has reported a slip and fall, resulting in injury of her jaw. The diagnoses have included attention deficit hyperactivity disorder, failed neck surgery syndrome, and right arm pain. Treatment to date has included cervical spine fusion, right shoulder surgery, physical therapy, electrodiagnostic studies, radiological imaging, medications, functional restoration program, and transcutaneous electrical nerve stimulation. Currently, the IW complains of continued right shoulder and neck pain. Physical findings are noted as tightness in the neck, but not tender, a normal gait, tenderness with swelling is noted at the left clavicle, but not the right. The records indicate a magnetic resonance imaging of the cervical spine was completed on January 13, 2014, which reveals cervical fusion, disc protrusion without cord compression, and disc herniation. On January 15, 2015, Utilization Review non-certified additional functional restoration program, fourteen days, for the right arm, and neck, based on Chronic Pain Medical Treatment guidelines. On January 26, 2015, the injured worker submitted an application for IMR for review of additional functional restoration program, fourteen days, for the right arm, and neck.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional restoration program for the right arm and neck, quantity: 14 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPS) Page(s): 49.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 31-33.

**Decision rationale:** Chronic pain programs (functional restoration programs) 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) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. The most commonly referenced programs have been defined in the following general ways (Stanos, 2006): (1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs: (a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus) (b) Multidisciplinary pain clinics (c) Pain clinics (d) Modality-oriented clinics (2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs. 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. There is no documentation that the patient is motivated to attend a functional restoration program. Also, there is no documentation that the patient is not a candidate for surgery or other therapies. There is no documentation of motor or sensory deficits causing significant functional loss. Therefore, the request is not medically necessary.