

Case Number:	CM15-0121547		
Date Assigned:	07/02/2015	Date of Injury:	06/07/1994
Decision Date:	07/31/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/23/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 68 year old female, who sustained an industrial injury on 6/07/1994. Diagnoses include controlled drug dependence, active drug dependence, depressive disorder, spondylosis with myelopathy, degeneration of intervertebral disc and disorder of trunk. Treatment to date has included medications including Amitriptyline, Celebrex, Cymbalta, Duragesic transdermal patch, Effexor, Evzio, Fentanyl patch, Hydrocodone, Meloxicam, Naproxen, Prilosec, Soma, Tizanidine, Trazodone, Voltaren gel and Zanaflex. Per the Primary Treating Physician's Progress Report dated 4/15/2015, the injured worker reported bilateral back pain and bilateral leg pain. The back pain is described as unchanged since her last visit. Physical examination of the back revealed decreased range of motion, right and left paraspinal tenderness with spasm and central spinal tenderness. Her right upper extremity has a sling due to recent shoulder surgery. The plan of care included medication management. Authorization was requested for 20 sessions of an interdisciplinary pain rehabilitation program.

IMR ISSUES, DECISIONS AND RATIONALES

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

20 Sessions of Inter-disciplinary pain rehabilitation program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Chronic pain programs (functional restoration programs), p30-32 (2) Functional restoration programs, Page(s): 30-32, 49.

Decision rationale: The claimant has a remote history of a work-related injury occurring in 1994 and continues to be treated for radiating low back pain. When seen, pain was rated at 8/10. Treatments had included medications, therapy, injections, and pain management. Medications included Fentanyl. There was a GAF of 65. Diagnoses were pain disorder, depression, and anxiety. Treatment for 20 days in a chronic pain program was requested. A functional restoration program can be recommended for selected patients with chronic disabling pain. Research is ongoing as to how to most appropriately screen for inclusion in these programs. Criteria for a multidisciplinary pain management program include an adequate and thorough evaluation, including baseline functional testing. In this case, a thorough evaluation including baseline testing is not documented. The request was not medically necessary.