

<b>Case Number:</b>	CM15-0170858		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	03/28/2012
<b>Decision Date:</b>	10/19/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, 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 57 year old female who sustained an industrial injury on 3-28-12 when she felt an increase in her pain involving her bilateral arms and neck and reports cumulative trauma. Diagnoses included cervical pain; cervical sprain, strain; cervical facet syndrome; lateral epicondylitis; ulnar neuropathy, left carpal tunnel syndrome; wrist pain; left ulnar neuropathy with left cubital tunnel syndrome; thoracic sprain, strain; sleep apnea; depressive disorder; generalized anxiety; pain disorder; myofascial pain syndrome. She currently complains of frequent headaches; neck pain that radiates down her shoulder blades and intermittently to her elbows; bilateral hand weakness which limits her ability to perform activities of daily living; depression; anxiety; irritability. She reports being frustrated, depressed and hopeless by the fact that she cannot do household chores or cook. She reports her pre-injury exercise was very little and now it consists of very slow short walks and some swimming. She is still driving. Her pain level was 7 out of 10 in her neck and 4 out of 10 in her wrists. Her sleep quality is poor and she uses continuous positive airway pressure machine. On physical exam of the cervical spine noted tenderness to palpation, limited cervical range of motion; weak bilateral handgrip; tenderness to palpation of bilateral lateral epicondyles, carpal tunnel area of bilateral wrists. Diagnostics included MRI of the cervical spine (12-5-13) abnormal; electromyography, nerve conduction study (2-25-13) abnormal and earlier testing as well. Treatments to date include physical therapy which failed to provide sustained functional improvement; acupuncture; chiropractic treatments, transcutaneous electrical nerve stimulator unit; injections; medications: Cymbalta, Percocet, Lyrica, Zanaflex, Ativan, Nexium, Valtrex, Zomig; she has declined carpal tunnel surgery. In the progress note dated 7-16-15 the treating provider's plan of care included a request for 10

sessions of functional restoration program to include: up to 2 hours of therapeutic exercise per day; 1 hour of cognitive behavioral therapy per day; 1 hour of education per day; 1 hour to lunch daily; 1 half hour of psychotherapy per day; 1 hour of group education for vocational counseling and work stimulation activities; 3 sessions of art therapy (1 hour each); 3 sessions of individual psychotherapy (pain psychologist sessions: 1 hour per session; 2 multidisciplinary sessions per week (1 hour each session); 2 sessions of family group meetings at 2 hours per session (patient education). The request for authorization dated 8-4-15 indicated 10 sessions of functional restoration program. On 8-10-15 utilization review evaluated and non-certified the request for 10 sessions of functional restoration program to include: up to 2 hours of therapeutic exercise per day; 1 hour of cognitive behavioral therapy per day; 1 hour of education per day; 1 hour to lunch daily; 1 half hour of psychotherapy per day; 1 hour of group education for vocational counseling and work stimulation activities; 3 sessions of art therapy (1 hour each); 3 sessions of individual psychotherapy (pain psychologist sessions-1 hour per session; 2 multidisciplinary sessions per week (1 hour each session); 2 sessions of family group meetings at 2 hours per session (patient education) based on the fact that many areas of the program are not recommended, therefore the whole program cannot be recommended.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**10 Sessions of functional restoration program to include: Up to 2 hours of therapeutic exercise/day; 1 hour of group CBT/day; 1 hour of patient education/day; 1 hour for lunch daily; 1/2 hour of psychotherapy/day; 1 hour of group education for vocational counseling and work stimulation activities; 3: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Chronic pain programs (functional restoration programs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic), Chronic Pain Programs.

**Decision rationale:** With regard to chronic pain programs, MTUS CPMTG states "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." The criteria for the general use of multidisciplinary pain management programs are as follows: "(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 are many of these outlined by the MTUS). Review of the submitted documentation indicates that the injured worker is has already undergone initial evaluation at [REDACTED]. Per that evaluation, it was determined that the injured worker has not been able to functionally improve

to any significant degree despite treatments to date. The injured worker meets the criteria for the use of an FRP. I respectfully disagree with the UR physician's denial based upon patient education and art therapy not being warranted. These components are part of the functional restoration program, which is indicated. The UR physician's assertion that "extensive patient education covering issues such, as chemical dependency, workers' compensation legal issues, family dynamic issues, etc. and art therapy are not warranted. Therefore, based on the fact that many areas of the program are not recommended, the whole program cannot be recommended." is not supported by any cited guidelines. There is nothing in MTUS, which states that extra modalities cannot be included in a multidisciplinary program. It is at the carrier's discretion to decide to reimburse extra for these programs or simply reimburse at fee schedule, however, extra modalities do not obviate the medical necessity of the core program. The request is medically necessary.