

<b>Case Number:</b>	CM15-0065259		
<b>Date Assigned:</b>	04/13/2015	<b>Date of Injury:</b>	11/07/2011
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal 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 injured worker is a 59-year-old male, who sustained an industrial injury on November 7, 2011. He reported feeling a pop in his low back with the immediate onset of lower back pain. The injured worker was diagnosed as having lumbosacral strain, industrially aggravated multilevel lumbar degenerative disc disease, chronic pain syndrome, predominantly lower back pain with some right-sided sciatica, pain disorder with both psychological and GMC chronic, chronic adjustment disorder unspecified and problems related to the social environment/occupational problems. Treatment to date has included diagnostic studies, medication, injection, psychological testing, psychotherapy, electrical stimulation and multidisciplinary care sessions. On January 20, 2015, the injured worker reported significantly decreased physical functional, social activity, recreational engagement and inability to work due to pain exacerbation. Notes stated he gained 30 pounds since his injury. He believes that his injury has led to feelings of anger and withdrawal from social relationships. The treatment plan included a Multidisciplinary Pain Rehabilitation Program and Cognitive Behavioral Therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Multidisciplinary pain rehabilitation program 10 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Multidisciplinary Pain Rehabilitation Program Integrative Summary Report, Functional Restoration Programs Page(s): 30-31.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restorative Guidelines Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Functional Restoration Program (FRP).

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, multidisciplinary pain rehabilitation program for 10 days is not medically necessary. A functional restoration program (FRP) is recommended when there is access to programs with proven successful outcomes (decreased pain and medication use, improve function and return to work, decreased utilization of the healthcare system. The criteria for general use of multidisciplinary pain management programs include, but are not limited to, the injured worker has a chronic pain syndrome; there is evidence of continued use of prescription pain medications; previous methods of treating chronic pain have been unsuccessful; and adequate thorough multidisciplinary evaluation has been made; once an evaluation is completed a treatment plan should be presented with specifics for treatment of identified problems and outcomes that will be followed; there should be documentation the patient has motivation to change and is willing to change the medication regimen; this should be some documentation the patient is aware that successful treatment may change compensation and/or other secondary gains; if a program is planned for a patient that has been continuously disabled from work more than 24 months, the outcomes for necessity of use should be clearly identified as there is conflicting evidence that chronic pain programs provide return to work beyond this period; total treatment should not exceed four weeks (24 days or 160 hours) or the equivalent in part based sessions. Total treatment duration should not generally exceed four weeks (20 full days or 160 hours), or the equivalent in part day sessions. If treatment duration in excess of four weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. Negative predictors of success include high levels of psychosocial distress, involvement in financial disputes, prevalence of opiate use and pretreatment levels. In this case, the injured workers working diagnosis is lumbosacral strain; industrial aggravated multilevel lumbar degenerative disc disease; chronic pain syndrome; low back pain with right sciatica; pain disorder with both psychological and GMC chronic adjustment disorder. A physician progress note dated March 5, 2015 summarizes the multidisciplinary pain rehabilitation to date. The injured worker has completed 10 sessions and has made functional gains in the multidisciplinary treatment setting. The treating physician states the injured worker requires further treatment. The injured worker has had improvement in many categories of ADLs. The injured worker is working closely with all team members to improve physical functioning and maintain job demands a detailed rationale for continuation of care in a multidisciplinary setting is set forth in the document. The injured worker has learned to incorporate active interventions such as stretching, deep breathing and light exercise as tools to manage pain. Additionally, the injured worker takes small walks for 15 to 30 minutes. The injured worker is compliant with the home program and motivation, and as normalization of life activities. The treating physician states the injured worker requires further treatment to maximize gains in pain related psychiatric comorbidities and to maintain the skills he has learned. He is making steady gains in improving symptoms of depression and anxiety and will require ongoing care to self manage pain levels and

group dynamics. He is working to reduce fears of re-injury and continues to challenge himself by managing his thought, emotional and behavioral patterns. The treating physician is requesting an additional 10 sessions of multidisciplinary care allowing the injured worker to regain full independence in daily activities and applying these techniques to work setting. Each session day consists of six patient contact hours. Each week consists of five session days or 30 patient contact hours. The treating physician is requesting 10 additional sessions of multidisciplinary care allowing the patient to regain full independence in daily activities and applying these techniques to work setting. The injured the treating physician requested 60 additional hours of multidisciplinary care. The utilization review physician determined the injured worker requires additional physical therapy and psychotherapy one time per week for eight weeks to monitor an independent home exercise program and coping based on continuing improvement in ADLs, and depression, etc. The documentation does not support an additional 60 hours of a multidisciplinary pain management program and is not clinically indicated. Consequently, absent clinical documentation to support an additional 10 sessions of multidisciplinary care based on the aforementioned documentation, multidisciplinary pain rehabilitation program for 10 days is not medically necessary.