

Case Number:	CM15-0070895		
Date Assigned:	04/20/2015	Date of Injury:	11/16/2012
Decision Date:	05/20/2015	UR Denial Date:	03/23/2015
Priority:	Standard	Application Received:	04/14/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 49-year-old female, who sustained an industrial injury on 11/16/12. The injured worker has complaints of low back pain with radiation to front of abdomen occasionally and radiates to bilateral lower extremity right greater than left lower extremity to toes with tingling/numbness and weakness in lower extremity. The diagnoses have included low back pain; thoracic pain and lumbosacral neuritis. Treatment to date has included physical therapy; injections and medications. The request was for functional restoration program for 10 days. The patient sustained the injury due to slip and fall incident. The patient had received cervical ESI for this injury. Patient has received an unspecified number of PT and CBT visits for this injury. The past medical history includes anxiety and depression. She had not worked since June 2013. Per the doctor's note dated 1/14/15 patient had complaints of pain and worsening function. Physical examination revealed normal gait and slow and guarded movement. The medication list includes Norco, Duloxetine, Gabapentin, Cyclobenzaprine and Ketoprofen. Physical examination of the lumbar spine on 2/24/15 revealed normal gait, normal heel-toe walk, limited range of motion, positive SLR, 5/5 strength and normal sensation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program for 10 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS (Effective July 18, 2009)Page 30-32Chronic pain programs (functional restoration programs).

Decision rationale: Functional Restoration Program for 10 days. According to the CA MTUS chronic pain medical treatment guidelines chronic pain programs (functional restoration programs) are "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." In addition per the cited guidelines "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; (6) Negative predictors of success above have been addressed."The criteria for chronic pain management program have not been met as per records provided. The patient has received an unspecified number of PT and chiropractic visits for this injury. A response to a complete course of conservative therapy including PT visits was not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. The pain evaluation of this patient (e.g. pain diary) was also not well documented and submitted for review. Baseline functional testing that documents a significant loss of ability to function independently resulting from the chronic pain was not specified in the records provided. In addition, per ODG, "The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain."The past medical history includes anxiety and depression. She had not worked since June 2013. The patient has an increased duration of pre-referral disability time: almost 2 years. There is conflicting evidence that chronic pain programs would provide return-to-work in this kind of patient. The medical necessity of the request for Functional Restoration Program for 10 days is not fully established for this patient. The request is not medically necessary.