

<b>Case Number:</b>	CM13-0019420		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	03/25/2009
<b>Decision Date:</b>	03/13/2014	<b>UR Denial Date:</b>	08/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in Illinois and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 50-year-old male who reported an injury on 03/25/2009, after he tripped and fell at work, landing on his back and injuring his neck and low back. The patient has undergone 14 sessions of physical therapy and chiropractic treatments from 2009 through 2010. He has also undergone massage therapy 18 times throughout 2010 through 2012, and an additional physical therapy for his lumbar spine times 10 sessions for 03/2013 through 06/2013. A QME diagnosis of cervical, thoracic, and lumbar strains were noted, as well as postconcussive syndrome on 01/25/2012. The patient was seen on 07/17/2013, with nonradiating pain described as a 5/10, sharp and throbbing in his back with tingling and weakness. The physician noted decreased ADLs but did not specify which activities were indicated. The patient was most recently seen on 12/20/2013, for ongoing pain in the back that radiates down from the lower back to the neck. At the time of the exam, the patient rated his pain as an 8/10, with the best being a 4/10. On average he rated his pain as a 6/10, and notated that it was constant and lasting throughout the day. He did not state any exacerbating factors but did note that the medications and walking did relieve his pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Capacity Evaluation:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation (FCE)

**Decision rationale:** The Physician Reviewer's decision rationale: Under Official Disability Guidelines it states that a Functional Capacity Evaluation should be considered if case management is hampered by complex issues such as a prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed exploration of a worker's abilities. Lastly, timing is appropriate as close to, or at MMI, and all key medical records should be secured and additional/secondary conditions should be clarified. In the case of this patient, the most recent documentation dated 12/20/2013, noted that the patient was on temporary total disability until the next appointment, there was nothing in the documentation indicating the patient had returned to work or is going to be returning to work with modified duties as well as working in an ergonomically functional capacity. Without having a thorough rationale for the requested service, the request for a Functional Capacity Evaluation cannot be supported at this time. As such, the requested service is noncertified.

**Functional Restoration Program Evaluation:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs), Page(s): 49.

**Decision rationale:** The Physician Reviewer's decision rationale: Regarding the request for a Functional Restoration Program Evaluation, according to California MTUS functional restoration programs were designed to use a medically directed interdisciplinary pain management approach geared specifically to patients with chronic disabling musculoskeletal disorders. It notes that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. In the case of this patient, because he has been on temporary total disability due to his low back pain, by incorporating this restoration program into his treatment plan the patient would benefit from the incorporation of components from exercising with disability management and psychosocial intervention. Therefore, in regards to the requested service, the functional restoration program evaluation would be considered medically appropriate and is certified.