

<b>Case Number:</b>	CM13-0024144		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	07/21/2008
<b>Decision Date:</b>	02/20/2014	<b>UR Denial Date:</b>	09/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/13/2013

### 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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in 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.

### 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 45-year-old male who reported an injury on 07/21/2008. The patient is currently diagnosed with lumbar disc displacement without myelopathy, stenosis of the lumbar spine, and sciatica. The patient was recently seen by [REDACTED] on 01/13/2014. The patient reported continuous 3/10 low back pain with radiation to the right lower extremity. Physical examination revealed tenderness to palpation, decrease range of motion, positive straight leg raising, decreased sensation along the left calf, 4/5 motor strength and 1+ and equal deep tendon reflexes at the patella and Achilles. Treatment recommendations included continuation of current medications and recommendations for a functional restoration program and a psychologic consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Initial Functional Restoration Program Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-33.

**Decision rationale:** California MTUS Guidelines state functional restoration programs are recommended, when there is access to programs with proven successful outcomes for patients

with conditions that put them at risk of delayed recovery. An adequate and thorough evaluation should be made, including baseline functional testing. There should be evidence that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. As per the clinical notes submitted, there is no documentation of a psychological evaluation and/or treatment. There is no documentation of a significant functional component that would necessitate an intensive functional program or indication of a substantial loss of the ability to function independently. The patient remains at maximum medical improvement, and there is no indication that the patient's current function has declined from a permanent and stationary level. There is also no evidence of a failure to respond to previous methods of treating chronic pain with an absence of other options that are likely to result in clinical improvement. Based on the clinical information received, the request is non-certified.