

<b>Case Number:</b>	CM13-0028803		
<b>Date Assigned:</b>	11/27/2013	<b>Date of Injury:</b>	06/26/2003
<b>Decision Date:</b>	04/17/2014	<b>UR Denial Date:</b>	08/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2013

### 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. The expert reviewer is Board Certified in Family Practice, 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 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/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 64-year-old male who reported an injury on 06/26/2003. The mechanism of injury was not provided. The patient underwent an L2-4 laminectomy with fluoroscopy on 11/19/2012. The office note of 08/20/2013 revealed that the patient felt fatigue and weakness, but was substantially better than preoperatively. The patient rated his pain at 2/10. It was indicated the patient had physical therapy visits. The diagnosis was noted to be status post lumbar decompression. The request was made for a Functional Restoration Program and evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 MULTIDISCIPLINARY FUNCTIONAL RESTORATION PROGRAM AND EVALUATION: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN PROGRAM, FUNCTIONAL RESTORATION PROGRAM Page(s): 30-32.

**Decision rationale:** California MTUS Guidelines indicate that the criteria for entry into a functional restoration program includes an adequate and thorough evaluation that has been made

including baseline functional testing so follow-up with the same test can note functional improvement, documentation of previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, documentation of the patient's significant loss of the ability to function independently resulting from the chronic pain, documentation that the patient is not a candidate for surgery or other treatments would clearly be warranted, documentation of the patient having motivation to change and that they are willing to forego secondary gains including disability payments to effect this change, and negative predictors of success has been addressed. Additionally it indicates the treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The clinical documentation submitted for review failed to indicate the patient had baseline functional testing. The request, as submitted, failed to indicate the duration for the requested program. The program is not supported for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Given the above, the request for 1 multidisciplinary functional restoration program and evaluation is not medically necessary.