

<b>Case Number:</b>	CM13-0053455		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/20/2008
<b>Decision Date:</b>	03/20/2014	<b>UR Denial Date:</b>	11/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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 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. 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 54-year-old female who reported an injury on 02/20/2008. Review of the medical record reveals the patient diagnoses include left foot internal derangement status post 3 plantar fascia surgeries with residuals; left ankle arthralgia; left knee internal derangement and lumbar spondylosis with lumbar disc herniations at L5-S1, and bilateral L5-S1 radiculopathy. The clinical note dated 10/30/2013 indicated the patient had low back and bilateral lower extremity pain with associated numbness and tingling. The patient complained of constant low back pain, left knee pain with swelling along the medial aspect of the knee, ongoing foot and ankle pain, radiating symptoms in the right lower extremity. Objective findings upon examination revealed the patient had an antalgic gait favoring the left lower extremity. Range of motion of the lumbar spine was limited, with normal lordosis, spasms, and guarding noted. There was a positive straight leg raise test noted on the right. Levels of depression, anxiety, and somatization all elevated over the community sample mean with levels of anxiety that were significantly elevated even over the pain patient sample mean. Treatment option reviewed with the patient included lumbar disc decompression and fusion at L5-S1, a trial of lumbar epidural steroid injections, and a functional restoration program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Initial Evaluation for Functional Restoration Program: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Chronic pain programs (functional restoration programs) Page(s): 32.

**Decision rationale:** Per Chronic Pain Medical Treatment Guidelines, it is stated that functional restoration programs are recommended when previous methods of treatment to chronic pain have been unsuccessful, and there is an absence of other options likely to result in sufficient clinical improvement. As other options were discussed with the patient to include surgeries or epidural steroid injections, and the patient elected not to participate in those options, the medical necessity for initial evaluation of functional restoration cannot be determined at this time. As there are still options that would help alleviate some of the patient's pain, the request for initial evaluation for a functional restoration program is non-certified.