

Case Number:	CM13-0065325		
Date Assigned:	01/03/2014	Date of Injury:	10/03/2010
Decision Date:	06/27/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/13/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 48-year-old male who reported an injury on 10/03/2010. The mechanism of injury was an altercation where a man ran after the injured worker and repeatedly punched him on the left side of his head, knocking his eyeglasses off and the phone out of his hand. The documentation of 11/06/2013 revealed the injured worker had a comprehensive interdisciplinary evaluation for a restoration program. The medications included Gabapentin 300 mg 3 times a day, Carisoprodol 350 mg twice a day, Hydrocodone/APAP 10/650 mg 3 times a day, Trazodone 50 mg at bedtime and Pantoprazole 20 mg twice a day. The examination revealed the injured worker had a significant fear of reinjury with movement or activity. The injured worker had moderate to severe diffuse tenderness to palpation in the supporting musculature of the paravertebral muscles and of the neck and low back. The injured worker had psychological testing. The injured worker had a strong desire to increase overall function and return to normal activities with his family. The diagnoses included cervicalgia, cervical radiculopathy, low back pain, low back sprain/strain, lower extremity radiculopathy, anxiety, and deconditioning. There was a documented treatment plan was presented and a physical therapy evaluation. The treatment plan included a functional restoration program for 180 hours.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE FUNCTIONAL RESTORATION PROGRAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN PROGRAMS (FUNCTIONAL RESTORATION PROGRAMS),.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Chronic Pain Program, Functional Restoration Program,.

Decision rationale: California MTUS Guidelines indicate that a Functional Restoration program is recommended for patients with conditions that put them at risk of delayed recovery. 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 injured worker was not a candidate for surgery or other treatments that would clearly be warranted. The request as submitted failed to indicate the duration for the functional restoration program. Given the above, the request for 1 functional restoration program is not medically necessary.