

<b>Case Number:</b>	CM14-0000736		
<b>Date Assigned:</b>	01/17/2014	<b>Date of Injury:</b>	02/09/2013
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	12/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2014

### 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 Medicine and is licensed to practice in California. 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:

This is a 30 year old male patient who reported an industrial injury on 2/9/2013, 19 months ago, attributed to the performance of his customary job tasks reported as lifting boxes and placing them on a conveyor belt when he fell back with his foot caught in a palate. The patient complained of lower back pain attributed to a sprain/strain. The patient reported neck pain radiating to the bilateral UEs. The patient complained of pressure and tingling to the right inguinal area. The objective findings on examination included slightly diminished range of motion of the cervical spine; Mark differences in temperature between the right and left leg/feet; right foot with dryer skin; diminished range of motion of the knees; SLR causes muscle spasms the my: tenderness to palpation to the paraspinous muscles of back and buttocks; lumbar spine range of motion diminished; pain with range of motion of the hips; pain to palpation of the right trochanteric area; strength testing normal to the arms; decreased sensation along the left neck, deltoid, medial/ventral forearm; light touch decrease in the medial right foot; decreased sensation left thenar, hypo thenar, ulnar forearm and medial lateral right foot. The treatment plan included MRI of the right hip to rule out structural changes; bone scan to rule out cold fracture; MRI of the cervical spine to evaluate for radiculopathy and cord compression. A comprehensive multidisciplinary assessment was ordered.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COMPREHENSIVE MULTIDISCIPLINARY ASSESSMENT:** 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 functional restoration program- Page(s): 30-32. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 3 page 92; chapter 3 page 127; chapter 6 pain, suffering, and functional restoration pages 113-115; chronic pain chapter 8/8/2008 interdisciplinary pain rehabilitation programs.

**Decision rationale:** The patient is currently being treated for a lower back pain; hip pain; and reported neck and upper extremity pain subsequent to falling backwards after catching his foot in a palette. The patient has been ordered MRIs; however, there is no documented objective findings of the results of the MRIs incorporated into a treatment plan. The patient is requested to receive a consultation for a FRP for chronic mechanical back pain, neck/UE and hip pain 19 months after the DOI. It is not clear why further conditioning and strengthening has not occurred with the previously provided sessions of physical therapy and the recommendations for a self-directed home exercise program. There is no demonstrated medical necessity for the requested functional restoration program as a requesting provider has not documented the criteria recommended by the California MTUS. The request for authorization of a consultation for evaluation of the patient for a FRP is not supported with objective evidence to support the medical necessity of the request for consultation for the formal functional restoration program. The patient is currently assessed as not making additional progress with persistent pain; however, it is not clear that the patient is participating in a self-directed home exercise program in order to return to work. The patient is 19 months s/p date of injury and is not demonstrated to have failed bona fide conservative care or participated in a self-directed home exercise program. There is objective evidence provided that the patient cannot be treated with the ongoing conservative treatment as provided without the intervention of a formalized FRP. There is no objective evidence that the FRP is medically necessary for the diagnosis of an unspecified pain issues as the evaluation of the patient is not complete. There is no significant documented objective evidence provided that supports the medical necessity of the requested consultation for a FRP as a requirement before returning to modified work. The appropriate treatment has not been demonstrated to have failed. The patient has a normal MRI of the lumbar spine and few objective findings on examination other than reported TTP and decreased ROM. The request is therefore not medically necessary.