

Case Number:	CM14-0001673		
Date Assigned:	01/22/2014	Date of Injury:	04/02/2003
Decision Date:	06/06/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/06/2014

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 Physical Medicine & Rehabilitation 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 52 year-old patient sustained an injury on 4/2/03. Report of 12/12/13 from the provider noted the patient with low back pain radiating to bilateral legs. Exam noted graded zero muscle stretch reflex at patella and Achilles; no clonus, midline vertebral incision-mildly painful to touch; positive slump test on right with referred pain to right calf; lumbar extension and lateral rotation to right side referred pain to right buttocks; lumbar extension and left rotation referred pain to left buttock; lumbar range restricted by pain; right EHL weakness graded 4/5. Previous treatment has included multiple lumbar spine surgeries, medications, epidural steroid injections, physical therapy, and chiropractic care; none of which has provided any substantial benefit.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 WEEKS OF FUNCTIONAL RESTORATION PROGRAM (50 HOURS): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs) Page(s): 30-34, 49.

Decision rationale: Guideline criteria for a functional restoration program requires at a minimum, appropriate indications for multiple therapy modalities including behavioral/

psychological treatment, physical or occupational therapy, and at least one other rehabilitation oriented discipline. Criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; A level of disability or dysfunction; No drug dependence or problematic or significant opioid usage; and a clinical problem for which a return to work can be anticipated upon completion of the services. There is no report of the above as the patient has unchanged symptoms and clinical presentation, without any aspiration to return to work with continued non-tapering opiate use. The 2 weeks of functional restoration program (50 hours) is not medically necessary and appropriate.