

Case Number:	CM14-0100086		
Date Assigned:	09/12/2014	Date of Injury:	04/30/2008
Decision Date:	10/16/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	06/30/2014

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 Practice and is licensed to practice in Texas and Oklahoma. 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 55-year-old female who reported injury on 04/30/2008. She was involved in an on the job injury while employed as a clerk. She sustained injury to her back and left leg from repetitive use. The injured worker's treatment history included: functional restoration; acupuncture restoration; pain program on 05/20/2011; anti-inflammatory medications; epidural steroid injections; lumbar spinal surgery; status post sacroiliac joint injection; and physical therapy. The injured worker was evaluated on 06/02/2014 and it was documented that the injured worker complained of continued low back pain, left leg pain, left hip pain and groin pain. The pain level was at 7/10 to 8/10. Examination of the lumbar spine revealed: palpable paraspinal muscle spasms; limited range of motion; flexion was 20% of normal, extension was 10% of normal, side to side bending was 50% of normal, left and right; motor strength was 5/5 proximally and distally bilaterally; normal sensation to light touch bilateral lower extremities; deep tendon reflexes; hyperreflexia 3+ bilateral knees and Achilles tendons. Straight leg raise was positive on the left lower extremities. She had spasms in the neck/thoracic region as well. Sacroiliac joints, pain and palpation over the left S1 joint. Faber was positive on the left. The left hip had some tenderness to palpation anteriorly with full range of motion, but pain with internal and external rotation of the left hip, 2+ equal bilaterally. The thoracic spine, there was pain to palpation in the midthoracic area with palpable paraspinal muscle spasm and limited range of motion. Flexion and extension were limited due to pain. Muscle guarding was noted due to pain. Diagnoses included: status post L4-5, L5-S1 laminectomy; status post cervical laminoplasty; postlaminectomy syndrome; facet arthropathy; left sacroiliitis; no evidence of instability in the lumbar spine or in flexion/extension x-rays; left hip pain; bladder incontinence, partial, residual since the cauda equina syndrome in 2009; discogenic pain of L4-5 and L5-S1 with radiculopathy/radiculitis; left lower extremity and right

ankle pain. The Request for Authorization dated 06/02/2014 was for a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, functional restoration program: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Function Restoration Page(s): 98-99, 7 and 30-31.

Decision rationale: The California MTUS Guidelines may support up to 10 visits of physical therapy for the treatment of unspecified myalgia and myositis to promote functional improvement. The Chronic Pain Medical Treatment Guidelines (MTUS) state that functional restoration is an established treatment approach that aims to minimize the residual complaints and disability resulting from acute and/or chronic medical conditions. Functional restoration is the process by which the individual acquires the skills, knowledge and behavioral change necessary to avoid preventable complications and assume or re-assume primary responsibility ("locus of control") for his/her physical and emotional well-being post injury. The individual thereby maximizes functional independence and pursuit of vocational and avocational goals, as measured by functional improvement. It also states multiple treatment modalities, (pharmacologic, interventional, psychosocial/behavioral, cognitive, and physical/occupational therapies) are most effectively used when undertaken within a coordinated, goal oriented, functional restoration approach. The diagnoses include low back pain. The documentation submitted for review failed to indicate if the injured worker had any prior physical therapy, pain management and long-term functional improvement outcome measurements. Additionally the injured worker has already attended a Functional Restoration Program on 04/11/2011 for two weeks. The request failed to include frequency or duration and location where physical therapy is required given the above, the request for Functional restoration program and physical therapy is not medically necessary.