

<b>Case Number:</b>	CM14-0123695		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	06/03/2011
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	07/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2014

### 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 and 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:

The injured worker is a 54-year-old male who reported an injury on 06/03/2011. The mechanism of injury was not provided within the review. His diagnoses were noted to be lumbago, lumbosacral neuritis, sacroiliac sprain on the right, and sciatic nerve lesion/piriformis syndrome. Prior treatments were noted to be chiropractic therapy and injections. An MRI of the lumbosacral spine showed disc bulge with degeneration throughout the lumbar spine, mainly L4-5, with a central right disc herniation. The injured worker had a clinical evaluation with subjective complaints of pain in the low back over the right sacroiliac area. He rated pain at a 5/10 to 6/10. Current medications were noted to be Tramadol, Flector, Flexeril, Aspirin, Doxazosin, and Glyburide. The physical examination noted limited range of motion of the right hip, tenderness on palpation of the right SI joint reproducing pain, and piriformis muscle tenderness on the right. Range of motion was decreased in the lumbosacral spine with right lateral flexion and extension due to pain. Palpation indicated moderate tenderness of the lumbosacral spine and paraspinals with mild paralumbar muscle tightness. The treatment was for a recommendation for further chiropractic treatments. The treatment plan also indicated a recommendation for a right sacroiliac joint/gluteal area injection. The provider's rationale for the request was not noted in the review. A Request for Authorization Form was not found within the documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional restoration program 5 times a week for 6 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs) Page(s): 49.

**Decision rationale:** The request for Functional restoration program 5 times a week for 6 weeks is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend a Functional Restoration Program, although research is still going on as to how to most appropriately screen for inclusion in these programs. These programs emphasize the importance of function over the elimination of pain. Functional restoration programs incorporate components of exercise progression with disability management and psychosocial intervention. Long term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The provider's request is in excess of the guidelines' recommendations as the guidelines recommend 2 weeks and the request is for 6 weeks. As such, the request for Functional Restoration Program 5 times a week for 6 weeks is not medically necessary.