

<b>Case Number:</b>	CM14-0146335		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	05/06/2008
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	08/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2014

### 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, has a subspecialty in Interventional Spine Pain Management 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 patient is a 29 year old male with an injury date of 05/06/08. The 06/11/14 report states that the patient presents with intermittent lower back pain rated 8-9/10. The patient has antalgic gait and he has returned to work with modified duty; however, the employer is unable to accommodate. Examination of the lumbar spine shows reduced range of motion on flexion with diminished sensation on the left L5-S1 dermatome with sensation diminished mainly in the left foot. The patient's diagnoses include: Musculoligamentous Sprain/Strain Lumbar Spine; Medial Meniscus Tear, Knee; Internal Derangement Knee; Disc Bulging Lumbar Spine; Adhesion/Caudal EPI; Stenosis Lumbar; Pain, Lumbar Spine; Status post L4-5, L5-S1 hemi-laminectomy and microdiscectomy, failed, 01/05/10; Chronic Pain and Disability and Adjustment Disorder with Depression, Anxiety and Insomnia. The utilization review being challenged is dated 08/20/14. Reports were provided from 03/28/14 to 06/11/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Full Functional Restoration Program (FRP) times 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 30-34.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines FRP, Criteria for the general use of multidisciplinary pain management programs Page(s): 49 and.

**Decision rationale:** The patient presents with intermittent lower back pain rated 8/10. The provider requests for Full Functional Restoration Program (FRP) times 4 weeks. The reports do not show the date of this request. The 08/20/14 Utilization review states the date of the RFA is 08/14/14. The MTUS guidelines pg. 49 recommends functional restoration programs and indicate it may be considered medically necessary when all criteria are met including (1) adequate and thorough evaluation has been made. MTUS Criteria for the general use of multidisciplinary pain management programs pages 30-33 states that treatment is not suggested for longer than 2 weeks without documented subjective and objective gains and that total treatment duration should generally not exceed 20 full-day sessions or the equivalent in part day sessions. Treatment in excess of 20 sessions requires a clear rationale and reasonable goals to be attained. In this case, the provider does not discuss this request in the reports provided. There is no evidence that an adequate and thorough evaluation has been made which is the first criterion to determine the medical necessity of this program. Furthermore, MTUS states that treatment should not be longer than 2 weeks without documented gains. The provider is requesting for 4 weeks of treatment, and prior treatment has not been documented as required by MTUS. Therefore, this request is not medically necessary.