

Case Number:	CM14-0175491		
Date Assigned:	10/28/2014	Date of Injury:	11/30/1999
Decision Date:	12/05/2014	UR Denial Date:	10/09/2014
Priority:	Standard	Application Received:	10/23/2014

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 64-year-old male who reported an injury on 11/30/1997. The mechanism of injury was not submitted for this review. Diagnoses included post laminectomy lumbar, cervical radiculopathy, and lumbosacral radiculopathy. The injured worker's prior treatment history included medications, back surgery, shoulder surgery, renal failure times 2, and fusion C2-C7. The injured worker was evaluated on 09/03/2014 and it was documented the injured worker complained of arm pain, back pain, and neck pain. It was noted that the injured worker had his cervical spinal cord stimulation system removed in 01/2014. The injured worker noticed significant psychological distress including depression/anxiety due to his current pain state. His current pain was 8/10 on the pain scale described as constant and sharp. Pain was located in the arms and neck and back. Pain was associated with numbness and weakness of bilateral upper and lower extremities. There were no bowel or bladder symptoms. Pain was noted as better with medication. Pain was worse with prolonged sitting, standing, and walking, as well as bending, lifting, twisting, and sneezing. Physical examination revealed the injured worker was able to rise from a seated position without difficulty. Gait was not antalgic and the injured worker ambulated without assistance. Decreased sensation to light touch and discrimination in the right leg globally. Examination noted atrophy of the left lower extremity, particularly in the quadriceps muscles. Medications included Percocet 10/325 mg and Neurontin 600 mg. Treatment plan included the provider wanted the injured worker to participate in a functional restoration program and noted the injured worker had taken initiative to walk one half mile to a mile daily before his recent surgeries, demonstrating a desire to do better in treatment of his pain; and he had conservative care including medical management, multiple attempts at physical therapy, and a cervical spine stimulator, bilateral shoulder surgeries, 1 posterior cervical fusion

in 01/2014 and 1 lumbar decompression also in 2014. Request for authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program: 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 Chronic pain programs (functional restoration programs) Page(s): 30-32.

Decision rationale: The request for a functional restoration program is not medically necessary. The California MTUS states that an adequate and thorough evaluation needs to be made, including baseline functional testing, so that follow-up with the same test can note functional improvement; previous methods of treating chronic pain have been unsuccessful; and there is an absence of other options likely to result in significant clinical improvement; the injured worker had a significant loss of the ability to function independently resulting from the chronic pain; the injured worker is not a candidate where surgery or other treatments would clearly be warranted; and the injured worker exhibits motivation to change. Negative predictors of success should also be addressed. Functional restoration treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Total treatment duration should generally not exceed 20 full day sessions, and treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. There was a lack of a measurable baseline against which to measure the efficacy of the functional restoration program. It was noted the injured worker failed conservative care measures, however the outcome measures of previous treatment was not submitted for review. Additionally, the request that was submitted for review failed to include duration of treatment for the functional restoration program. As such, the request for functional restoration program is not medically necessary.