

Case Number:	CM14-0030649		
Date Assigned:	06/20/2014	Date of Injury:	03/14/1998
Decision Date:	08/04/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/10/2014

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, has a subspecialty in International Spine 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 52 year old female with an injury date on 03/14/1998. The listed diagnoses per [REDACTED] dated 12/30/2013 are: 1. Lumbosacral disc injury. 2. Lumbosacral radiculopathy involving bilateral S1 level. 3. Depression. 4. Lumbosacral sprain/strain injury. According to this report, the patient complains of low back pain and left leg pain flare up due to the cold weather. The patient has restricted lumbosacral range of motion and positive straight leg raise. The patient's current medications are Voltaren XR100mg and Norco. There were no other significant findings noted on this report. The utilization review denied the request on 02/27/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 01/18/2013 to 03/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

One functional restoration program evaluation for diagnosis of lumbar (lower back) disc displacement and lumbosacral radioculopathy, as an outpatient: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) , chapter 7, page 127.

Decision rationale: According to the 12/30/2013 report by [REDACTED] this patient presents with low back pain and left leg pain. The treater is requesting one functional restoration program evaluation for diagnosis of lumbar (lower back) disc displacement and lumbosacral radioculopathy. Regarding functional restoration programs, California Medical Treatment Utilization Schedule (MTUS) guidelines pg. 49 recommends it when all criteria are met including (1) adequate and thorough evaluation has been made (2) Previous methods of treating chronic pain have been unsuccessful (3) significant loss of ability to function independently resulting from the chronic pain; (4) not a candidate for surgery or other treatments would clearly be (5) The patient exhibits motivation to change (6) Negative predictors of success above have been addressed. Review of the reports do not indicate the patient has been provided a thorough evaluation as to whether or not the patient may be a candidate for Functional Restoration Program (FRP). The requested one functional restoration program evaluation is medically necessary and appropriate.