

Case Number:	CM14-0068211		
Date Assigned:	07/14/2014	Date of Injury:	04/05/2013
Decision Date:	08/14/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/13/2014

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 Pain Medicine and is licensed to practice in Texas. 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 58-year-old male who reported an injury on 04/05/2013. His diagnoses include a backache. His previous treatments included chiropractic care and over-the-counter medications. On physical examination, the physician reported the injured worker had absolutely no difficulty in turning, twisting, bending to demonstrate his mechanism of injury and to demonstrate the exercise program he had been doing. The physician's impression included cervical straining injury and low back pain. The physician reported neurologically the injured worker was normal and had no reason to preclude him from doing his usual and customary duties. Within the most recent clinical note dated 04/01/2014, the injured worker was in for a followup visit regarding his injuries. The injured worker reported he had ongoing pain in his back that radiated up to his head. He rated his pain at a 5/10 and indicated it was exacerbated by bending, carrying, cold, coughing, crouching, driving, exercise, fatigue, and lifting. He reported the pain was relieved by heat, medications, ice, and relaxation. On physical examination, the physician reported the left hip flexion was 4/5, right hip flexion was 5/5, left knee extension was 4/5, and right knee extension was 5/5. The SI joint compression test and slump test were noted as positive. The physician reported the injured worker had not responded well to previous methods of treatment, including physical therapy and medications. He reported the injured worker was motivated to improve and was committed to overall functional improvement and compliance with treatment goals. He also reported the injured worker did not display any negative predictors and he was not a surgical candidate. The injured worker had issues putting on his shoes and socks and noted it had been difficult for him. The current request is for Consult with FRP (functional restoration program) to see he is a candidate for the program. The Request for Authorization was provided on 04/08/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consult with FRP (functional restoration program) to see if a candidate for the program:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-32. Decision based on Non-MTUS Citation ACOEM Guidelines 2nd edition, Chapter 6: Pain, suffering and functional restoration, pages 113-114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-32.

Decision rationale: The MTUS Chronic Pain Guidelines state that prior to admission to a functional restoration program, an adequate and thorough evaluation should be made, including baseline functioning testing so followup with the same test can note functional improvement. Additionally, documentation should show that previous methods of treating chronic pain have been unsuccessful, there is an absence of any other options to result in significant clinical improvement, and the injured worker has a significant loss of ability to function independently, resulting from chronic pain. Additionally, the MTUS Chronic Pain Guidelines recommend that the treatment is not suggested for longer than 2 weeks without evidence of objective gains. The clinical documentation provided for review showed that the injured worker had persistent low back pain and had previously been treated with chiropractic care and medications. In addition, there was no documentation provided to indicate the injured worker had participated in a physical therapy and psychological evaluation as required by the guidelines. Therefore, the injured worker does not meet the criteria for admission into a functional restoration program at this time. As such, the request is not medically necessary and appropriate.