

<b>Case Number:</b>	CM14-0072993		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	04/12/2013
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/20/2014

### 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 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 40-year-old male with an injury date of 04/12/13. Based on the 04/17/14 progress report provided by [REDACTED], the patient complains of moderate lower back pain with intermittent radiation into the right lower extremity, which is worse in the afternoons. It is a burning, throbbing pain with some weakness. The patient reports that his pain has negatively affected his ability to perform his activities of daily living and household chores. Straight leg raise is positive in a seated position at 70 degrees with lower back pain increase and radiating into right lower extremity. There is tenderness at midline between L3 and L5. Sensory is decreased over the right L4 and L5 dermatome to pinprick, light touch and temperature. His diagnoses include the following: thoracic or lumbosacral neuritis or radiculitis not otherwise specified and chronic pain syndrome. [REDACTED] is requesting for an initial evaluation/interdisciplinary evaluation for functional restoration program for the lower back. The utilization review determination being challenged is dated 04/23/14. [REDACTED] is the requesting provider, and he provided treatment reports from 12/26/13- 04/22/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Initial evaluation/interdisciplinary evaluation for functional restoration program, low back:** Overturned

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

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

**Decision rationale:** According to the 04/17/14 report by [REDACTED], the patient presents with moderate lower back pain with intermittent radiation into the right lower extremity. The request is for an initial evaluation/ interdisciplinary evaluation for functional restoration program for the lower back. MTUS guidelines page 49 recommends functional restoration programs for chronic pain. A 2-week program is recommended if all of the criteria are met. In this case, the request is for an evaluation to determine the patient's candidacy for a functional restoration program. Given the patient's chronic low back pain, recommendation is for medical necessity of the requested evaluation.