

<b>Case Number:</b>	CM14-0094916		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	03/05/2007
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2014

### 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 Texas and Ohio. 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 31-year-old male who reported an injury on 03/05/2007. The diagnoses include lumbosacral sprain/strain, lumbosacral disc injury, lumbosacral radiculopathy, and myofascial pain syndrome. The previous treatments included medication, physical therapy, chiropractic treatment, electroacupuncture treatment, ESIs. Within the clinical note dated 06/12/2014, it was reported the injured worker complained of symptomatic pain and discomfort. Upon the physical examination, the provider noted the injured worker had a decreased lumbosacral range of motion. Motor strength was 5/5 in the lower extremities. The injured worker had a positive straight leg raise in the left leg. The provider requested a functional restoration program. However, a rationale was not provided for clinical review. The Request for Authorization was not provided for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Restoration Program, Evaluation and 2 weeks of treatment for the Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (functional restoration programs); Opioids Page(s): 30-32, 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration program (Chronic Pain Program) Page(s): 30, 32.

**Decision rationale:** The request for Functional Restoration Program, Evaluation and 2 weeks of treatment for the Lumbar Spine is non-certified. The California MTUS Guidelines recommend functional restoration programs where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. The guidelines also recommend 6 criteria's for functional restoration program outlet program, outpatient pain rehab program may be considered medically necessary when all of the following criteria are met including (1) an adequate and thorough evaluation has been made including baseline functional testing so follow-up with the same test can note functional improvement. (2) The previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. (3) The injured worker has significant loss of ability to function independently resulting from chronic pain. (4) The injured worker is not a candidate for surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether the surgery may be avoided.) (5) The injured worker exhibits motivation to change and is willing to forego secondary gains, including disability payments, to affect this change. (6) Negative predictor of success above have been addressed. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. There is lack of documentation including an adequate and thorough evaluation of baseline functional testing to provide functional improvement in future tests. There is lack of significant documentation indicating the injured worker has had previous methods of treatment which have been unsuccessful. There is significant lack of documentation indicating the injured worker had significant loss the ability to function independently resulting from chronic pain. Additionally, the request submitted for 2 weeks of treatment exceeds the guidelines recommendations of a trial of 10 visits may be implemented to assess whether surgery may be avoided. Therefore, the request is not medically necessary.