

<b>Case Number:</b>	CM14-0205177		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	09/10/1986
<b>Decision Date:</b>	02/11/2015	<b>UR Denial Date:</b>	11/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This is a 54 year old patient with date of injury of 09/10/1986. Medical records indicate the patient is undergoing treatment for failed back syndrome, sacroiliac disease and peripheral neuropathy. Subjective complaints include lower back pain that radiates down left leg and increases when walking and working. The patient's pain is rated 7/10. Objective findings include 4/5 EHL bilaterally; sensory intact. Treatment has consisted of lumbar fusion, physical therapy, home exercise program, TENs unit, Lumbar Spinal cord stimulator trial, Lidocaine injection, Flexeril, Zanaflex, Tramadol, Ultram, Cyclobenzaprine, Ambien and Norco. The utilization review determination was rendered on 11/06/2014 recommending non-certification of Functional Restoration Program Evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Restoration Program Evaluation:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Office Visits

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Program, Detoxification, Functional Restoration Programs Page(s): 30-34, 42, 49.

**Decision rationale:** MTUS states that, "Long-term evidence suggests that the benefit of these programs diminishes over time", "Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." and "Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved." At the time of the previous review the patient had pending surgery. The patient has had surgery and the treating physician has provided a medical rationale to meet MTUS guidelines. As such, the request for Functional Restoration Program Evaluation is medically necessary.