

<b>Case Number:</b>	CM14-0079201		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	07/17/2013
<b>Decision Date:</b>	01/09/2015	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2014

### 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 Emergency Medicine 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:

This injured worker has a reported date of injury on 7/17/2013. The mechanism of injury is described as a lifting injury. The primary diagnosis is lumbago. The lumbar MRI of 9/19/13 revealed mild facet arthropathy with mild proximal bilateral neural foraminal narrowing at L3-4, L4-5 and L5-S1. There were no bulges, and no root compression or stenosis. The injured worker is also reporting pain in the neck, shoulders and knees. Pain is 7-10/10. Treatment includes a Butrans patch. Per the physician reports at the time of this request, there was lumbar paraspinal and upper gluteal region with decreased range of motion. Strength of the left lower extremity was a generalized 3/5 weakness. There was decreased sensation to the left medial and lateral thigh. Straight leg raising was positive bilaterally. The report of 6/12/14 discusses the denial of FRP based on the lack of conservative therapy, and plans for prescribing physical therapy. On 5/28/14 Utilization Review recommended non-certification of the FRP based on lack of conservative therapy previously.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) 10-day trial of Functional Restoration Program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 31-32.

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

**Decision rationale:** As per the MTUS Chronic pain guidelines, certain criteria should be met before recommendation to a program. Criteria which are not met include: 1) "Failure of prior chronic pain treatment". There is no documentation of prior chronic pain management plan with adequate conservative therapy attempted prior to the FRP request. 2) "Motivation to change and return to work". The injured worker appears depressed and has stated that he has no plans of returning to prior work. Depression should be treated prior to an attempt of an FRP. 3) "Negative predictors for success have been addressed". The injured worker appears to have psychological issues that need to be addressed prior to an FRP. The injured worker has yet to fail usual conservative therapy and treatment of his psychological issues. The Functional Restoration Program is not medically necessary.