

<b>Case Number:</b>	CM15-0000287		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	12/05/2012
<b>Decision Date:</b>	03/09/2015	<b>UR Denial Date:</b>	12/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 42 year old male, who sustained an industrial injury on 12/05/2012. A pain management follow up visit dated 10/02/2014 reported the patient being status post left knee arthroscopic meniscus repair on 05/21/2013. He did undergo physical therapy sessions and continued treatment conservatively with oral medications and home exercise program. As a result of his chronic pain, the patient has developed some psychosocial complications, such as anxiety, fear-avoidance, depression and sleep disorder, which have limited his functional recovery. He did undergo psychological evaluation on 05/16/2014 and was treated with cognitive behavioral therapy which reported had improved symptoms of anxiety and depression, but did not apply to his functional capacity. Regardless, the patient is reported as highly motivated to improve. He did return to work on light duty for two weeks but could not withstand and was taken back out of work. The patient continues to have moderately severe lower back pain and left knee pain. The pain is noted worse in the mornings and evenings. It's described as dull, aching, shooting, throbbing pain with numbness and tingling to the lower extremities. Physical examination found lumbar spine range of motion is restricted with flexion limited to 50 degrees by pain and extension is limited to 20 degrees. On palpation, paravertebral muscles, tenderness noted on the right side. Spinous process tenderness is noted on L2, L3, L4 and L5. Straight leg raising test is negative bilaterally. Bilateral knees have restricted range of motion with flexion limited to 100 degrees by pain and extension is limited to 170 degrees also limited by pain. The following are currently prescribed medications; Tramadol ER, Cyclobenzaprine, Naproxen Sodium, Pantoprazole Sodium, Quazepam and Methoderm Gel. A psychology and

behavioral medicine follow up visit dated 11/28/2014 reported the patient with continued complaint of depressed and disappointed; In addition, he complained of being lonely. He is diagnosed with; major depressive disorder, single episode, chronic/moderate rule out generalized anxiety and pain disorder. On 12/09/2014 Utilization Review non-certified a request for functional restoration program treating left knee and lumbar regions, noting CA MTUS functional restoration program was cited. On 01/02/2015, the injured worker submitted an application for IMR for review of the requested service.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Functional restoration program (number of sessions not provided): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 30-33.

**Decision rationale:** This patient presents with chronic low back and left knee pain. The current request is for a FUNCTIONAL RESTORATION PROGRAM (NUMBER OF SESSIONS NOT PROVIDED). As documented in progress report dated 11/25/14, the patient is a good candidate for FRP after CBT is completed. The MTUS page 30 to 33 recommends functional restoration programs and indicates it may be considered medically necessary when all criteria are met including, 1. Adequate and thorough evaluation has been made, 2. Previous methods of treating chronic pain have been unsuccessful, 3. Significant loss of ability to function independently resulting from the chronic pain, 4. Not a candidate for surgery or other treatment would clearly be warranted, 5. The patient exhibits motivation to change, 6. Negative predictors of success above have been addressed. In this case, an evaluation has not taken place. MTUS states functional restoration programs are indicated only after adequate and thorough evaluation has been made. This request IS NOT medically necessary.