

Case Number:	CM15-0104530		
Date Assigned:	06/08/2015	Date of Injury:	06/15/2013
Decision Date:	07/09/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/01/2015

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 was a 57-year-old female, who sustained an industrial injury, June 15, 2013. The injured worker previously received the following treatments acupuncture therapy, Tylenol, Anaprox, protonix, lumbar epidural injections and surgery. The injured worker was diagnosed with lumbar spine strain, lumbar radiculopathy and degenerative joint disease of the lumbar spine with protrusion at L1, L2, L3, L4 and L5-S1. According to progress note of March 25, 2015, the injured workers chief complaint was flare-ups for lower back pain wit work activities. The injured worker walked with a non-antalgic gait and was able to heel and toe walk without difficulty. The physical examination of the lumbar spine noted mild right lower muscle spasms. There was tenderness with palpation over the upper, mid and lower paravertebral muscles. There was decreased range of motion flexion of 15 degrees, right lateral bending of 15 degrees, left lateral bending of 20 degrees, right lateral rotation of 15 degrees and left lateral rotation of 20 degrees and extension of 10 degrees. There was increased pain with flexion and extension. The straight leg raising and rectus femoris stretch sign did not demonstrate any nerve irritability. There was patchy decreased sensation in the bilateral lower extremities, right more than the left in the L5 and S1 distribution. The treatment plan included a functional restoration therapy for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration therapy 2 times a week for 3 weeks for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines, Chronic Pain Programs (Functional Restoration Programs), pages 30-34, 49.

Decision rationale: It is unclear why the patient requires a Functional Restoration Program evaluation at this time. The clinical exam findings remain unchanged and there is no documentation of limiting ADL functions or significant loss of ability to function independently resulting from the chronic pain. Submitted reports have not specifically identified neurological and functional deficits amendable to a FRP with motivation for work status change. Per MTUS Chronic Pain Treatment Guidelines, criteria are not met. At a minimum, there should be appropriate indications for multiple therapy modalities including behavioral/ psychological treatment, physical or occupational therapy, and at least one other rehabilitation-oriented discipline. Criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; A level of disability or dysfunction; No drug dependence or problematic or significant opioid usage; and A clinical problem for which a return to work can be anticipated upon completion of the services. There is no report of the above nor is there identified psychological or functional inability for objective gains and measurable improvement requiring a functional restoration evaluation. Medical indication and necessity have not been established. The Functional Restoration therapy 2 times a week for 3 weeks for the lumbar spine is not medically necessary and appropriate.