

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0106081 | | |
| Date Assigned: | 06/10/2015 | Date of Injury: | 04/18/2011 |
| Decision Date: | 07/13/2015 | UR Denial Date: | 05/27/2015 |
| Priority: | Standard | Application Received: | 06/02/2015 |

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 59 year old male who sustained an industrial injury on 04/18/11. Initial complaints and diagnoses are not available. Treatments to date include medications, psychological counseling, lumbar epidural steroid injection, left piriformis muscle injection, sacroiliac joint injection, and chiropractic treatments. Diagnostic studies include MRIs of the lumbar spine and right wrist, neither of which is available for review. Current complaints include low back and right wrist pain. Current diagnoses include low back and hand pain, as well as lumbar spinal stenosis. In a progress note dated 04/21/15, the treating provider reports the plan of care as a Functional Restoration Program. The requested treatment is a Functional Restoration Program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional restoration program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs), early intervention, intensity, opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program (FRPs), page 49.

Decision rationale: Guidelines criteria for a functional restoration program requires at a minimum, 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. Guidelines criteria does support to continue a functional restoration program beyond initial treatment trial sessions; however, requires clear rationale and functional improvement from treatment rendered along with reasonable goals to be achieved with specific individual care plans and focused goals. Submitted reports have not demonstrated clear rationale to support further sessions beyond the recommendations of the guidelines. The functional restoration program not medically necessary and appropriate.