

<b>Case Number:</b>	CM15-0147574		
<b>Date Assigned:</b>	08/10/2015	<b>Date of Injury:</b>	04/18/2011
<b>Decision Date:</b>	09/04/2015	<b>UR Denial Date:</b>	07/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2015

### 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 64 year old male who sustained an industrial injury on April 18, 2011. A primary treating office visit dated January 12, 2015 reported subjective complaint of chronic low back pain. The pain level is noted fluctuating with activity levels. There is very little radiation of pain into the lower extremity. He states that exercise, medications, and the use of a transcutaneous nerve stimulator unit, and massage does help reduce the pain. He is able to continue the home exercise program and activities of daily living with the daily use of Norco 5mg and 325mg and Protonix. He is not currently working. The following diagnoses were applied: long term use of medications; lumbar disc displacement without myelopathy, and degeneration lumbar lumbosacral disc. The plan of care noted his condition unchanged and stable with persistent low back pain. There is mention of an injection with denial. He will continue with conservative treatment advocating active lifestyle and possible home exercise program. Recent urine drug screening s noted consistent with prescribed. He is permanent and stationary and will follow up in 4 weeks. On February 11, 2105 the treating diagnoses were: long term use of medications; lumbar disc displacement without myelopathy; spondylosis lumbosacral without myelopathy; degeneration lumbar lumbosacral disc, and sciatica. On March 27, 2015 at a follow up visit the plan of care noted mention of previous recommendation to be evaluated for a functional restoration program which must have been denied. The worker was previously deemed as permanent and stationary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional restoration program (FRP) initial evaluation:** Upheld

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

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

**Decision rationale:** The worker was previously deemed as permanent and stationary and continues not working for this injury of 2011. 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 return to work status. 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 program (FRP) initial evaluation is not medically necessary or appropriate.