

<b>Case Number:</b>	CM15-0205578		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	04/14/2014
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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, Hawaii  
 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:

This is a 41 year old female with a date of injury on 4-14-14. A review of the medical records indicates that the injured worker is undergoing treatment for chronic back pain. Progress report dated 9-14-15 reports continued complaints of right sided back with right leg radicular symptoms. She reports significant loss of her ability to function independently. Objective findings: she has an antalgic gait on the right and uses a single point cane, lumbar spine range of motion is limited, right lower extremity weakness and reflexes are normal in bilateral lower extremities. CT scan lumbar spine 4-16-14 revealed disc protrusion at L4-5 encroaching on the right L4 nerve root. MRI lumbar spine showed improvement in the right lateral disc protrusion at L4-5 without neural compression. Electro-diagnostic studies on 5-4-15 revealed mild chronic right L4 and L5 radiculopathy with increased irritation. Treatments include: medication, chronic pain physical therapy, psychotherapy, and epidural steroid injections. Request for authorization dated 9-16-15 was made for Functional Restoration Program 5 days per week for 6 weeks. Utilization review dated 9-21-15 modified the request to certify Functional Restoration Program 5 days per week for 2 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Restoration Program 5 days per week for 6 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

**Decision rationale:** The patient presents with right-sided back and right leg radicular symptoms. The current request is for Functional Restoration Program 5 days per week for 6 weeks. The treating physician's report dated 09/14/2015 (58B) states, "She underwent a thorough evaluation, which included baseline functional testing, so follow-up with the same tests can note functional improvement. Previous treatments of her chronic pain have been unsuccessful, and this has included extensive care including long periods of rest, medication trials, physical therapy, psychotherapy, and an epidural steroid injection. She is not interested in additional injections and is not a surgical candidate per spine surgeon [REDACTED]. An FRP has previously been recommended by her QME, [REDACTED]. She has demonstrated a significant loss of ability to function independently because of her pain. She is motivated to change so that she can return to work. The negative predictors of success were addressed and were not found to be a barrier to her participation in a formal functional restoration program." The MTUS Guidelines page 30 to 32 recommends Functional Restoration Programs when all of the following criteria are met including: 1. Adequate and thorough evaluation has been made. 2. Previous methods of treating chronic pain had been unsuccessful. 3. Significant loss of the ability to function independently resulting from chronic pain. 4. Not a candidate for surgery or other treatments would clearly be warranted. 5. The patient exhibits motivation change. 6. Negative predictor of success above has been addressed. These negative predictors include evaluation for poor relationship with employer, work satisfaction, negative outlook in the future, etc. The MTUS guidelines page 30 - 33 on chronic pain programs (functional restoration programs) states, "treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans and proven outcomes, and should be based on chronicity of disability and other known risk factors for loss of function." While the required criteria has been addressed, treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The current request is not medically necessary.