

Case Number:	CM15-0020486		
Date Assigned:	02/11/2015	Date of Injury:	09/17/2010
Decision Date:	03/25/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	02/03/2015

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 56 year old female, who sustained an industrial injury on 9/17/2010. The diagnoses have included pain disorder associated with both psychological factors and a general medical condition. Treatment to date has included surgical intervention and conservative treatments. On 8/18/2014, the injured worker complained of chronic left knee, low back, neck, and ankle pain. She reported increased back stiffness and decreased range of motion, but continued to report that medications helped with pain and function. She reported depressive symptoms and denied suicidal ideation. Physical exam noted an appropriate mood and affect. Gait was antalgic and she was ambulatory without assistance. Tenderness to palpation was noted to the lumbosacral region and muscle tension was noted at the low back extending into the mid back region. Motor strength was mildly decreased with left foot dorsiflexion and left leg extension compared to the right lower extremity. Current medications included Senna, Zofran, Morphine Sulfate ER, Norflex ER, Bupropion, Citalopram, Gabapentin, Lorazepam, and Omeprazole. Treatment plan noted status post [REDACTED] Functional Restoration Program. She continued with home exercise program and coping skills. Work status was "permanent and stationary". Functional Restoration Program progress notes were submitted 9/30/2013 to 11/08/2013. On 1/14/2015, Utilization Review non-certified a retrospective request for [REDACTED] Functional Restoration Program x10, noting the lack of compliance with MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE [REDACTED] Functional Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs), pages 30-34, 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, not seen here. 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 as the patient has unchanged chronic pain symptoms and clinical presentation without failure from conservative treatment rendered. There is also no specific psychological issues or diagnosis demonstrated or evaluation documenting medical necessity for a functional restoration program. Current medication profile and functional status remained unchanged. The RETROSPECTIVE [REDACTED] Functional Restoration Program is not medically necessary and appropriate.