

Case Number:	CM15-0213010		
Date Assigned:	11/02/2015	Date of Injury:	08/01/2012
Decision Date:	12/18/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	10/29/2015

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, 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 male who sustained a work-related injury on 8-1-12. Medical record documentation on 10-9-15 revealed the injured worker was being treated for chronic intractable low back pain, lumbar degenerative disc disease, lumbar spine disc herniations, bilateral lower extremities radiculitis, neuropathic pain, greater trochanteric bursitis of the bilateral hips, and cervical radiculitis of the left upper extremity. The injured worker continued to complain of severe constant neck pain and low back pain with shooting pain in the upper and lower extremities. He reported no improvement since his previous evaluation and reported that his pain worsens with prolonged standing and lifting. He had mild improvement with rest and medications. Objective findings included positive Spurling's test. He had no tenderness to palpation or muscle spasms in the cervical paraspinal muscles. His motor testing was 5-5 in all muscle groups of the upper extremities. He had diminished sensation of the C6 nerve root distribution. His cervical spine range of motion was normal in all directions, but he had pain with extension and lateral bending to the right and left. His lumbar spine examination revealed tenderness to palpation in the lumbar paraspinal muscles and muscle spasms in the paralumbar musculature. He was unable to toe-heel walk. His lumbar spine range of motion included forward flexion to 30 degrees, extension to 10 degrees. He had positive straight leg raise at 90 degrees bilaterally and diminished sensation in the L4-S1 nerve root distributions. He had tenderness to palpation over the bilateral trochanteric bursa and normal bilateral hip range of motion. His treatment plan included referral to a functional restoration program for his chronic intractable pain. Previous treatment included acupuncture therapy which was beneficial and the injured worker had psychotherapy sessions. A request for functional restoration program was received on 10-14-15. On 10-20-15, the Utilization Review physician determined functional restoration program was not medically necessary.

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 Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

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

Decision rationale: The patient presents with severe constant neck pain and lower back pain with shooting pain down the upper and lower extremities. The current request is for Functional Restoration Program. The treating physician's report dated 10/09/2015 (6B) states, the patient is indicated for a Functional Restoration Program for his chronic intractable pain. He will continue chronic pain management in the interim, and be prescribed and dispensed Diclofenac XR 100mg, 60, for anti-inflammatory. Patient referred for Functional Restoration program as recommended by CCR 9792.24.2, as part of a Chronic Pain Guideline contained in MTUS. For patient such as this where previous methods of treating chronic pain have been unsuccessful and there is absence of other options likely to result in significant clinical improvement. 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. While the physician has mentioned that previous treatments have been unsuccessful to treat chronic pain and that the patient has lost the ability to function independently; there is no documentation of the patient's motivation to change and the negative predictors of success. In this case, not all of the required criteria for a functional restoration program has been met. The current request is not medically necessary.