

<b>Case Number:</b>	CM15-0217592		
<b>Date Assigned:</b>	11/09/2015	<b>Date of Injury:</b>	01/09/2015
<b>Decision Date:</b>	12/21/2015	<b>UR Denial Date:</b>	10/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 29 year old male who sustained a work-related injury on 1-9-15. He reported an injury to his low back with radiation of pain to the right lower extremity. Medical record documentation on 10-9-2015 revealed the injured worker reported chronic low back pain with radiation of pain to the right lower extremity with associated numbness and tingling. He rated his pain a 6-7 on a 10-point scale and prolonged walking, standing, sitting or heavy lifting aggravated his pain. He reported continuation of home exercise program but had difficulty. He was not working as modified duties were not available. Previous treatment included gabapentin with no benefit. Objective findings included no abnormalities in gait or station and normal muscle tone without atrophy of the bilateral upper extremities and the bilateral lower extremities. His right lower extremity muscle strength was 5-5 in all tested muscle groups except right ankle dorsiflexion which was 4-5. He had decreased sensation of the right Sacroiliac joint and negative straight leg raise. His diagnoses included lumbosacral intervertebral disc displacement, lumbosacral intervertebral disc degeneration and lumbago with sciatica. Previous treatment included chiropractic therapy which provided only temporary benefit and massage therapy which reduced his low back pain temporarily. An MRI of the lumbar spine on 3-27-15 is documented as revealing degenerative disc disease and facet disease at T12-L1 and the lower lumbar spine. A request for functional restoration program was received on 10-16-15. On 10-21-15, 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 (160 hours): Upheld**

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

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

**Decision rationale:** The claimant sustained a work injury in January 2015 when he had low back pain while lifting a wheelbarrow. He was evaluated for a functional restoration program in October 2015. Treatments had included 7 sessions of physical therapy with some benefit. He had a flare-up of symptoms when trying to perform home exercises and was seen in an Emergency Room where a CT scan was done. Medications prescribed had been gabapentin and a muscle relaxant. Modified duty had not been accommodated. When seen he had pain rated at 6-7/10 with radiating symptoms into the right lower extremity. He was continuing to perform a home exercise program but was having difficulty. Physical examination findings included lumbar tenderness with decreased and painful range of motion. There was decreased right L5 sensation. An MRI of the lumbar spine in March 2015 included findings of a right lateralized disc protrusion at T12/L1 and central disc protrusions at L4/5 and L5/S1. Authorization for 160 hours of participation in the functional restoration program is being requested. In terms of a functional restoration program, criteria include that the patient has a significant loss of the ability to function independently due to chronic pain, previous methods of treating chronic pain have been unsuccessful, and that there is an absence of other options likely to result in significant clinical improvement. In this case, the claimant has clinical findings of a right L5 radiculopathy. He has not failed conservative treatments such as medications, injections, chiropractic care, or acupuncture and would likely benefit from a six-visit trial of physical therapy in order to revise his home exercise program. He has been release to modified work and is not being prescribed any opioid medication which indicates that he does not have functionally disabling pain. A functional restoration program is not medically necessary.