

<b>Case Number:</b>	CM15-0044085		
<b>Date Assigned:</b>	03/16/2015	<b>Date of Injury:</b>	05/07/2014
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 27 year old female who sustained an industrial injury on 5/7/14. The injured worker reported symptoms in the back. The injured worker was diagnosed as having pain disorder associated with both a general medical condition, and psychological factors, depressive disorder, chronic pain and chronic axial low back pain. Treatments to date have included activity modification, oral pain medications, physical therapy, heating pad, non-steroidal anti-inflammatory drugs, and oral muscle relaxant. Currently, the injured worker complains of chronic pain, anxiety, depression and insomnia. The patient has had depressive disorder. The plan of care was for a functional restoration program and a follow up appointment at a later date. The patient sustained the injury when she was helping a resident. The medication list include Hydrocodone, Ibuprofen and Flexeril. Per the doctor's note dated 1/29/15 patient had complaints of low back pain at 7/10. Physical examination of the low back revealed tenderness on palpation, normal sensation, strength and reflexes, negative SLR and Patrick test. She has had MRI of the lumbar spine on 08/15/2014 that revealed degenerative disc disease. Patient has received an unspecified number of PT visits for this injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Restoration Program, 2 weeks, 10 days and 60 hours: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS (Effective July 18, 2009) Chronic pain programs (functional restoration programs) Page(s): 30-32.

**Decision rationale:** Request: Functional Restoration Program, 2 weeks, 10 days and 60 hours. According to the CA MTUS chronic pain medical treatment guidelines chronic pain programs (functional restoration programs) are "Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below." In addition per the cited guidelines Criteria for the general use of multidisciplinary pain management programs-Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (6) Negative predictors of success above have been addressed. Physical examination of the low back revealed normal sensation, strength and reflexes, negative SLR and Patrick test. Any significant functional deficits that would require chronic pain management program was not specified in the records provided. The patient has received an unspecified number of PT and chiropractic visits for this injury. A response to a complete course of conservative therapy including PT visits was not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. The pain evaluation of this patient (e.g. pain diary) was also not well documented and submitted for review. Baseline functional testing that documents a significant loss of ability to function independently resulting from the chronic pain was not specified in the records provided. In addition, per ODG, "The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain." The patient has had depressive disorder. The medical necessity of the request for Functional Restoration Program, 2 weeks, 10 days and 60 hours is not fully established for this patient.