

Case Number:	CM14-0140508		
Date Assigned:	09/10/2014	Date of Injury:	11/12/2012
Decision Date:	10/10/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	08/29/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 31-year-old male who reported an injury on 11/12/2012. The mechanism of injury was not submitted for review. The injured worker has diagnoses of sprain of lumbar region, low back pain, lumbar disc pain, lumbar disc herniation with radiculopathy at the L5-S1 level, reactive depression, and chronic pain syndrome. Past medical treatment consists of surgical, physical therapy, aquatic therapy, and medication therapy. Medications consist of hydrocodone/acetaminophen, Zoloft, Lunesta, Xanax, Flexeril and Sprix nasal spray. On 09/03/2013 the injured worker underwent an MRI of the lumbar back which revealed no evidence of residual or recurrent disc protrusion in the L5-S1 region. There was mild protrusion of the L5-S1 disc in the central and right paracentral regions without significant compression of the thecal sac or nerve roots. On 07/23/2014 the injured worker complained of low back pain. Physical examination revealed that the injured worker had a pain rating of 7/10 with medications and 10/10 without. He had 4+/5 on the left lower extremity and 5-/5 right lower extremity strength secondary to pain. Patellar deep tendon reflexes were 2 on the left and 2+ on the right. Sensation was intact. Sciatic notches were painful to palpation bilaterally and sacroiliac joints were tenderness to palpation bilaterally. Patrick's sign and Gaenslen's maneuver were not tested secondary to pain. It was noted that the injured worker had tenderness over the lumbar paraspinals with myofascial restrictions and muscle spasm. Range of motion was limited on all plains secondary to pain. Straight leg raise was positive on the left. The treatment is for the injured worker to undergo a functional restoration program. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to a Functional Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Functional Restoration Programs), Page(s): 30-32.

Decision rationale: The request for a Referral to a Functional Restoration Program is not medically necessary. The California MTUS Guidelines states that an adequate and thorough evaluation needs to be made, including baseline functional testing, so that follow-up with the same test can note functional improvement; previous methods of treating chronic pain have been unsuccessful, and there is an absence of other options likely to result in significant clinical improvement; the patient had a significant loss of ability to function independently resulting from the chronic pain; the patient was not a candidate where other treatments would clearly be warranted; and the patient exhibited motivation to change. Negative predictors of success should be addressed as well. Functional restoration treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The treatment duration should generally not exceed 20 full day sessions, and a treatment duration in excess of 20 sessions requires a clear rationale for the specific extension and reasonable goals to be achieved. The submitted documentation lacked any indication of a measurable baseline against which to measure the efficacy of the functional restoration program. Additionally, there was a lack of evidence that the injured worker had failed conservative treatment to include physical medicine and medications. Furthermore, the request as submitted did not specify how long the provider was requesting the functional restoration program for. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request for a Referral to a Functional Restoration Program is not medically necessary.