

Case Number:	CM14-0144366		
Date Assigned:	09/12/2014	Date of Injury:	04/12/2002
Decision Date:	10/10/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	09/05/2014

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 Occupational Medicine 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:

According to the records made available for review, this is a 60-year-old male with a 4/12/02 date of injury. At the time (6/18/14) of request for authorization for 1 Functional restoration program for 2 weeks, there is documentation of subjective (ongoing low back pain radiating to the bilateral lower extremities aggravated with activities) and objective (lumbosacral tenderness to palpation with painful range of motion and positive straight leg raise bilaterally) findings, current diagnoses (failed back syndrome, history of lumbosacral disc injury, history of L4L5 lumbosacral decompression and fusion surgery, and right S1 lumbosacral radiculopathy), and treatment to date (electro-acupuncture, TENS unit, medications, physical therapy, and lumbar surgery). In addition, interdisciplinary functional restoration program evaluation report identifies baseline functional testing; that previous methods of treating chronic pain have been unsuccessful; the patient has had significant losses in his ability to function independently resulting from chronic back pain and right lower extremity pain; the patient is no longer a surgical candidate; the patient is motivated to participate in the program; specific goals have been outlined; negative predictors of success have been addressed; and there is no secondary gain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program for 2 Weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPs).

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that an adequate and thorough evaluation has been made, including baseline functional testing so 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 has a significant loss of ability to function independently resulting from the chronic pain; the patient is not a candidate where surgery or other treatments would clearly be warranted; and the patient exhibits motivation to change, as criteria necessary to support the medical necessity of a functional restoration/chronic pain program. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies that treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documentation by subjective and objective gains. Within the medical information available for review, there is documentation of diagnoses of failed back syndrome, history of lumbosacral disc injury, history of L4L5 lumbosacral decompression and fusion surgery, and right S1 lumbosacral radiculopathy. In addition, there is documentation that an adequate and thorough evaluation has been made, including baseline functional testing so 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 has a significant loss of ability to function independently resulting from the chronic pain; the patient is not a candidate where surgery or other treatments would clearly be warranted; and the patient exhibits motivation to change. Therefore, based on guidelines and a review of the evidence, the request for a Functional Restoration Program for 2 Weeks is medically necessary.