

Case Number:	CM14-0147227		
Date Assigned:	09/15/2014	Date of Injury:	02/26/2008
Decision Date:	10/15/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/10/2014

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 Family 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:

This is a 34 year female patient who reported an industrial injury on 2/26/2008, over 6 years ago, attributed to the performance of her usual and customary job tasks. The patient is being treated for chronic left lower extremity symptoms. The patient is been diagnosed with thoracic or lumbosacral neuritis or radiculitis in RSD. Patient currently presents with reported pain in her pelvis, groin, and left leg with constant left an intermittent right numbness in the lower extremities. The objective findings on examination included decreased lumbar spine range of motion; lumbar gluteal region tenderness on palpation; antalgic gait; decreased left hip and knee flexion during swing phase; decreased stance on the left; left tibialis anterior and extensor house longest weakness. The patient has undergone rehabilitative measures; physical therapy; medications; chiropractic care/CMT; acupuncture; along with epidural steroid injections. The patient had a FRP evaluation and was reported to have functional limitations that might respond in an FRP.

IMR ISSUES, DECISIONS AND RATIONALES

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

10 Initial sessions of a functional restoration program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 92, Chronic Pain Treatment Guidelines functional restoration Page(s): 30-32. Decision based on Non-MTUS Citation chapter 6 pain, suffering, and functional restoration pages 113-115; Official Disability Guidelines (ODG) pain chapter-functional restoration programs; chronic pain programs

Decision rationale: The patient is currently being treated for a lower back and LLE pain subsequent to the reported industrial injury over six (6) years ago. The patient is requested to have the first 10 days of a FRP for chronic mechanical back pain/LLE pain six (6) years after the DOI. It is not clear why further conditioning and strengthening has not occurred with the previously provided sessions of physical therapy and the recommendations for a self-directed home exercise program. There is no demonstrated medical necessity for the requested functional restoration program, as a requesting provider has not documented the criteria recommended by the California MTUS. The patient is currently assessed as not making additional progress with persistent pain; however, it is not clear that the patient is participating in a self-directed home exercise program in order to return to work. The patient is six (6) years s/p date of injury and is not demonstrated to have failed bona fide conservative care or participated in a self-directed home exercise program. There is objective evidence provided that the patient cannot be treated with the ongoing conservative treatment as provided without the intervention of a formalized FRP. There is no objective evidence that the FRP is medically necessary for the diagnosis of an unspecified pain issues reported as lower back pain with RSD symptoms to the left lower extremity, as the evaluation of the patient is not complete. There is no significant documented objective evidence provided that supports the medical necessity of the requested consultation for a FRP as a requirement before returning to modified work. The appropriate treatment has not been demonstrated to have failed. The patient has few objective findings on examination other than reported TTP and decreased ROM. Therefore, the request for 10 Initial sessions of a functional restoration program is not medically necessary and appropriate.