

<b>Case Number:</b>	CM14-0165785		
<b>Date Assigned:</b>	10/10/2014	<b>Date of Injury:</b>	05/30/2013
<b>Decision Date:</b>	11/13/2014	<b>UR Denial Date:</b>	09/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2014

### 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 Orthopedic Surgery 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:

57-year-old female claimant with an industrial injury dated 05/30/13. MRI of the lumbar spine dated 08/06/13 demonstrates a right kidney cyst while the thoracic MRI dated 09/03/13 reveals mild degenerative disc disease. The patient is status post a right hip lateral repair, femur and acetabular osteoplasty, iliotibial band fasciotomy and bursectomy dated 02/28/14. Conservative treatments have included medications, physical therapy, and pain management counseling. Exam note 09/09/14 states the patient returns with low back and right knee pain. Upon physical exam the patient demonstrated a restricted range of motion. Range of motion of the lumbar spine was decreased with extension, right and left lateral bending to 75%. Also the patient had bilateral sacroiliac joint and paravertebral muscle tenderness. There was also evidence of mild right knee crepitus upon examination. Diagnosis includes hip pain, hip bursitis, low back pain, sprain lumbar region, myofascial pain syndrome, chronic pain syndrome, and sprain thoracic region. Treatment includes a functional restoration program implementing a home exercise program and to taper medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Restoration Program Evaluation regarding the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 30-32.

**Decision rationale:** According to the California Medical Treatment Utilization Schedule (MTUS)/Chronic Pain Medical Treatment Guidelines, Chronic Pain programs (functional restoration programs), pages 30-32, is recommended when patients have conditions that put them at risk for delayed recovery. In addition criteria includes "previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. " In this case the exam note from 9/3/14 demonstrates myofascial and chronic pain syndrome and there is lack of documentation in the cited records of previous methods of treating chronic pain have failed. Therefore the requested treatment is not medically necessary and appropriate.