

<b>Case Number:</b>	CM15-0171833		
<b>Date Assigned:</b>	09/14/2015	<b>Date of Injury:</b>	07/01/2013
<b>Decision Date:</b>	10/19/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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:

This 26 year old male sustained an industrial injury on 7-01-13. The injured worker is being treated for lumbar radiculitis, lumbar strain and radiculopathy. Treatments to date include MRI testing, injections and work restrictions. Medications prescribed include Amrix, Flexeril, Duexis, Norco, Ambien and Ketoprofen as well as use of medical marijuana. The injured worker has continued complaints of low back pain on 9/14/2015. Upon examination of the lumbar spine, lumbosacral tenderness to palpation with painful range of motion was noted. Lumbar range of motion was reduced. Straight leg raising test was positive bilaterally. Per the progress note dated 6-12-15, the injured worker still has a lot of pain and discomfort involving low back and legs, therefore the request for FRP evaluation was made. The request for Functional Restoration Program evaluation at [REDACTED] was made by the treating physician. The patient has had MRI of the lumbar spine on 11/5/13 that revealed disc protrusions, foraminal narrowing, and mild central canal stenosis; EMG of lower extremity on 2/26/14 that revealed bilateral S1 radiculopathy. Patient had received lumbar ESI for this injury. The patient had received an unspecified number of psychotherapy and 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 evaluation at [REDACTED]:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter (Online Version) Chronic pain programs (functional restoration programs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Chronic pain programs (functional restoration programs).

**Decision rationale:** Functional Restoration Program evaluation at [REDACTED]. 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." The injured worker has continued complaints of low back pain on 9/14/2015. Upon examination of the lumbar spine, lumbosacral tenderness to palpation with painful range of motion was noted. Lumbar range of motion was reduced. Straight leg raising test was positive bilaterally. The patient has had MRI of the lumbar spine on 11/5/13 that revealed disc protrusions, foraminal narrowing, and mild central canal stenosis; EMG of lower extremity on 2/26/14 that revealed bilateral S1 radiculopathy. The patient has chronic pain beyond the expected time for recovery. He is on multiple medications including controlled substances. An initial one time EVALUATION to determine the necessity of a chronic pain management program is deemed medically appropriate and necessary in this patient at this time. The request for Functional Restoration Program evaluation at [REDACTED] is medically necessary and appropriate for this patient.