

<b>Case Number:</b>	CM15-0035873		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	05/31/2009
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	02/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 33 year old male, who sustained an industrial injury on 05/31/2009. The initial complaints or symptoms included low back pain. The initial diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, x-rays, MRIs, conservative therapies, spinal cord stimulator trial, lumbar discectomy and laminotomy, injections, and functional capacity evaluation (12/05/2014). Currently, the injured worker complains of continued low back pain with intermittent radiation into the left lower extremity. The diagnoses include lumbar displacement of intervertebral disc and lumbar radiculopathy. The treatment plan consisted of 6 weeks of participation in a functional restoration program, and L5-S1 transforaminal epidural injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Restoration Program, 6 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program Page(s): 30-34 and 49.

**Decision rationale:** Regarding the request for a functional restoration or chronic pain program, California MTUS support these types of programs when: 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; The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success above have been addressed. Within the medical information available for review, the patient has had a thorough evaluation of baseline functional testing, and clearly functional restoration program would benefit this patient. However, the guidelines recommend a two-week trial to assess the efficacy of a functional restoration program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The current request for 6 weeks of functional restoration program is excessive and not medically necessary.