

Case Number:	CM15-0079132		
Date Assigned:	04/30/2015	Date of Injury:	07/08/2002
Decision Date:	05/29/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/24/2015

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

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 52 year old male, who sustained an industrial injury on 07/08/2002. On provider visit dated 03/24/2015 the injured worker has reported low back and bilateral lower extremity pain. On examination, he was noted to have a decreased range of motion of lumbosacral area. There was a positive straight leg raise noted bilaterally. There was light touch sensation present in both lower extremities with motor strength noted as 5-/5 for both legs. The diagnoses have included failed back pain syndrome, lumbosacral disc injury, lumbosacral radiculopathy, lumbosacral fusion in 2003 and lumbosacral hardware removal in 2013. Treatment to date has included functional restoration program evaluation on 03/18/2015, laboratory studies and acupuncture. The provider requested functional restoration program for 2 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) functional restoration program for 2 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs), pages 30-34, 49.

Decision rationale: Guidelines criteria for a functional restoration program requires at a minimum, appropriate indications for multiple therapy modalities including behavioral/psychological treatment, physical or occupational therapy, and at least one other rehabilitation oriented discipline, not seen here. Criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; A level of disability or dysfunction; No drug dependence or problematic or significant opioid usage; and a clinical problem for which a return to work can be anticipated upon completion of the services. There is no report of the above as the patient has unchanged chronic pain symptoms and clinical presentation without failure from conservative treatment rendered. Submitted reports have not demonstrated acute changes, new injury, progressive deterioration, or specific limited ADLs to support for the FRP. There are also no psychological issues demonstrated or evaluation documenting medical necessity for a functional restoration program. The One (1) functional restoration program for 2 weeks is not medically necessary and appropriate.