

<b>Case Number:</b>	CM15-0091835		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	09/10/2014
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2015

### 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:

The injured worker has complaints of low back pain on 4/2/15 that radiates to lower extremity left greater than right with numbness and tingling sensation in bilateral feet/soles and neck pain that radiates to upper arms and still has regular headaches that requires him to take Tylenol every day. The diagnoses have included cervical sprain/strain neck; lumbar degenerative disc disease and lumbosacral radiculitis. The medication list includes Gabapentin. Physical examination of the cervical and lumbar spine revealed limited range of motion and tenderness on palpation and positive SLR. Treatment to date has included gabapentin for sleeping/nerve pain; chiropractic treatments; electromyography/nerve conduction velocity with no evidence of peripheral neuropathy or radiculopathy; home exercise program and magnetic resonance imaging (MRI) in thoracic no disc bulge or herniation, minimal desiccation of several discs, minimal facet arthropathy and unremarkable paraspinal structure. The request was for Functional Restoration Program. Patient has received an unspecified number of PT and chiropractic visits for this injury. The patient has had X-ray of the low back on 9/24/14 that revealed disc space narrowing; EMG on 11/5/14 that revealed lumbar radiculopathy; the patient has had MRI of the low back on 12/23/14 that revealed disc bulge with foraminal narrowing, and facet hypertrophy. The patient has had psychological symptoms including anxiety, depression, tension, crying spell, mood changes, frustration and anger. The patient sustained the injury when he was trying to chop wood with shovel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Restoration Program: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS (Effective July 18, 2009) Chronic pain programs (functional restoration programs) Page(s): 30-32.

**Decision rationale:** Functional Restoration Program. 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 criteria for chronic pain management program have not been met as per records provided. Patient has received an unspecified number of PT visits for this injury. A response to a complete course of conservative therapy including PT visits was not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. The pain evaluation of this patient (e.g. pain diary) was also not well documented and submitted for review. Baseline functional testing that documents a significant loss of ability to function independently resulting from the chronic pain was not specified in the records provided. In addition, per ODG, "The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) increased duration of pre-referral disability time; (8) higher prevalence of opioid use; and (9) elevated pre-treatment levels of pain." Patient has had a depressive disorder. The medical necessity of the request for Functional Restoration Program is not fully established for this patient. Therefore, the request is not medically necessary.