

Case Number:	CM13-0044152		
Date Assigned:	12/27/2013	Date of Injury:	01/22/2011
Decision Date:	11/06/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/28/2013

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 Physical Medicine and Rehabilitation 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:

According to the records made available for review, this is a 57-year-old male with a 1/22/11 date of injury, and status post left wrist surgery 2/11 and 8/11. At the time (10/17/13) of request for authorization for Functional Restoration Program of [REDACTED] Carpal Tunnel Release (CTR) evaluation and 2 weeks treatment, there is documentation of subjective (pain and discomfort involving the low back, neck, and left wrist) and objective (decreased cervical and lumbosacral range of motion, local tenderness and swelling at the left wrist) findings, current diagnoses (left wrist fracture, left wrist sprain/strain injury, and history of left wrist surgery x 2 2011), and treatment to date (medications, acupuncture and activity modification). 10/2/13 medical report identifies that the patient does not want any more surgery. There is no documentation that there is an absence of other options likely to result in significant clinical improvement; that the patient has a significant loss of ability to function independently resulting from the chronic pain; that the patient is not a candidate where other treatments would clearly be warranted; and that the patient exhibits motivation to change.

IMR ISSUES, DECISIONS AND RATIONALES

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

FUNCTIONAL RESTORATION PROGRAM OF [REDACTED] EVAL AND 2 WEEKS TREATMENT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 31-32.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that 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; and the patient exhibits motivation to change, as criteria necessary to support the medical necessity of chronic pain program evaluation. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that an adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; 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; and the patient exhibits motivation to change, as criteria necessary to support the medical necessity of a functional restoration/chronic pain program. Within the medical information available for review, there is documentation of diagnoses of left wrist fracture, left wrist sprain/strain injury, and history of left wrist surgery x 2 2011. In addition, there is documentation that previous methods of treating chronic pain have been unsuccessful and that the patient does not want any more surgery. However, there is no documentation that there is an absence of other options likely to result in significant clinical improvement; that the patient has a significant loss of ability to function independently resulting from the chronic pain; that the patient is not a candidate where other treatments would clearly be warranted; and that the patient exhibits motivation to change. In addition, pending a certification of a functional restoration program evaluation, there is no documentation that an adequate and thorough evaluation has been made. Therefore, based on guidelines and a review of the evidence, the request for Functional Restoration Program of [REDACTED] [REDACTED] Carpal Tunnel Release (CTR) evaluation and 2 weeks treatment is not medically necessary.