

<b>Case Number:</b>	CM13-0061812		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/28/2003
<b>Decision Date:</b>	04/11/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2013

### 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, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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:

The patient is a 64-year-old female who reported an injury on 02/28/2003. The mechanism of injury is not specifically stated. The patient is currently diagnosed with chronic left knee pain, status post total knee replacement, neuropathic pain, and left pes anserine bursitis. The patient was seen by [REDACTED] on 11/08/2013. The patient reported persistent pain with activity limitation. It is noted that the patient has been treated with greater than 24 sessions of physical therapy, chiropractic treatment, and opioid and non-opioid medication. Physical examination revealed tenderness to palpation of the right trochanteric bursa, decreased sensation to light touch in the medial and lateral aspect of the left knee, and tight hamstrings. Treatment recommendations included a Functional Restoration Program evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PROSPECTIVE REQUEST FOR 1 FUNCTIONAL RESTORATION PROGRAM EVALUATION: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-33.

**Decision rationale:** California MTUS Guidelines state Functional Restoration Programs are recommended where there is access to programs with proven successful outcomes for patients with condition that place them at risk of delayed recovery. An adequate and thorough evaluation should be made. Negative predictors of success should be addressed. As per the documentation submitted, the patient's injury was greater than 10 years ago to date. There is no available documentation of a return to any form of modified work duty. The patient continues to report significant pain and dysfunction. The patient is well beyond the point of delayed recovery and negative predictors of success are present. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.