MAXIMUS Federal Services

Case Number:	CM13-0065623		
Date Assigned:	01/03/2014	Date of Injury:	07/29/2011
Decision Date:	05/19/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	12/13/2013

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 48-year-old female with a 7/29/11 date of injury. At the time (10/3/13) of request for authorization for ten (10) Functional Restoration Program for the right wrist, there is documentation of subjective (pain and discomfort regarding the right wrist and hand) and objective (localized swelling and tenderness Final Determination Letter for IMR Case Number CM13-0065623 3 in the right elbow and wrist) findings, current diagnoses (De Quervain's synovitis, bilateral epicondylitis, and possible right median neuropathy and repetitive strain injury), and treatment to date (physical therapy, activity modification, TENS, acupuncture, and medications). There is no 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 and that the patient is not a candidate where surgery or other treatments would clearly be warranted.

IMR ISSUES, DECISIONS AND RATIONALES

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

TEN (10) FUNCTIONAL RESTORATION PROGRAM FOR THE RIGHT WRIST:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs/Functional Restoration Programs Page(s): 32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs) Page(s): 30-32.

Decision rationale: The 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. In addition, Chronic Pain Medical Treatment Guidelines identifies that treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documentation by subjective and objective gains. Within the medical information available for review, there is documentation of diagnoses of De Quervain's synovitis, bilateral epicondylitis, and possible right median neuropathy and repetitive strain injury. In addition, there is 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; and the patient exhibits motivation to change. However, there is no 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 and that the patient is not a candidate where surgery or other treatments would clearly be warranted. Therefore, based on guidelines and a review of the evidence, the request for ten (10) Functional Restoration Program for the right wrist is not medically necessary and appropriate.