

<b>Case Number:</b>	CM13-0069108		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	07/12/2003
<b>Decision Date:</b>	05/23/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/20/2013

### 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:

The injured worker is a 69-year-old male who reported an injury on 07/12/2003. The mechanism of injury was not stated. Current diagnoses include Kienbock's disease of the left lunate status post surgery, chronic pain syndrome, and new onset of numbness and tingling in the fingers. The injured worker was evaluated for an interdisciplinary functional restoration program on an unknown date. It is noted that the injured worker has completed 24 occupational therapy sessions following surgery in 2004. The injured worker reported increasing pain with activity limitation. Current medications include Advil, Tylenol, Tramadol, and Coumadin. Physical examination revealed an inability to fully make a fist in the left upper extremity, 1+ edema to the mid forearm, decreased temperature on the left side, decreased sensation to light touch in the dorsum and volar aspect of the left wrist, 4/5 strength, 50% normal range of motion, and decreased sensation in the volar and dorsal aspect of the forearm and wrist. Treatment recommendations at that time included 2 weeks in a functional restoration program/chronic pain program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TWO WEEKS OF FUNCTIONAL RESTORATION PROGRAM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009) Chronic pain programs (functional restoration programs).

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

**Decision rationale:** The California MTUS Guidelines state functional restoration programs are recommended where there is access to programs with proven successful outcomes for patients with conditions that place them at risk of delayed recovery. There should be evidence 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. Negative predictors of success should also be addressed. Total treatment duration should generally not exceed 20 full day sessions. As per the documentation submitted, the injured worker has completed 24 occupational therapy sessions following surgery in 2004. However, there was no mention of a recent attempt at conservative treatment prior to the request for a chronic pain program. The injured worker has also reported ongoing depression and anxiety, which has not been formally managed. There is no documentation of this injured worker's active participation in a home exercise program to reduce the frequency of pain flares. Based on the aforementioned points, the injured worker does not currently meet criteria for the requested program. As such, the request is not medically necessary.