

<b>Case Number:</b>	CM13-0071781		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	07/11/2005
<b>Decision Date:</b>	06/05/2014	<b>UR Denial Date:</b>	12/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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 & Rehabilitation and is licensed to practice in Illinois. 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 57 year old male who reported an injury on 07/11/2005 secondary to a motor vehicle accident. The diagnoses include chronic quadricep weakness, chronic neuropathy, status post ACL repair and meniscectomy, status post ORIF of the left tibia and chronic pain syndrome. The injured worker was evaluated on 09/25/2013 for reports of ongoing pain, decreased function, symptoms of depression and fear of re-injury leading to avoidance of activity. The injured worker reported 4-7/10 pain radiating down the left leg and foot, occasional sleep disturbance and slight decrease in energy. The exam noted a Beck Depression Inventory of 10, Hospital Anxiety and Depression Scale of 10/21, Beck Anxiety Inventory of 11 and a Pain Disability Index of 29/70, indicating the injured worker feels mildly depressed, borderline anxious and some feelings of disability. The exam also noted pain with palpation to the left patella, atrophy of the quadricep on the left, decreased range of motion with flexion with 10 degree deficit noted. The plan of care is a functional restoration program for two weeks with 50 hours of contact time. The request for authorization was signed on 08/05/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FUNCTIONAL RESTORATION PROGRAM FOR 2 WEEKS, WITH 50 HOURS OF CONTACT TIME:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPs), Page(s): 31-32.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Page(s): 31-33.

**Decision rationale:** The request for functional restoration program for two weeks with 50 hours of contact time is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend functional restoration programs when an adequate evaluation has been performed, previous methods of pain reduction have failed, there is significant loss in ability to function independently due to chronic pain, the injured worker is not a candidate for surgery, the injured worker exhibits motivation to change and any negative predictors of success have been addressed. Although a thorough evaluation has been performed, the injured worker has shown significant reduction in activity due to pain, is not a candidate for other surgeries and exhibits a willingness to change; there is a lack of evidence of previous cognitive behavioral therapy trials to address the injured workers fears of re-injury and mild depression and anxiety resulting in limited activity. Therefore, based on the documentation provided, the request is not medically necessary.