

Case Number:	CM13-0072619		
Date Assigned:	01/17/2014	Date of Injury:	06/15/2007
Decision Date:	04/28/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	12/31/2013

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 Pain Management 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 patient is a 42 year old female who was injured on 06/15/2007 and 11/07/2008 as a result of prolonged typing and keyboarding and prolonged sitting. Prior treatment history has included Intralaminar epidural steroid injection at L5-S1 and L3-L4 dated 10/15/2013. She has undergone extensive conservative management with 12 sessions of acupuncture, six weeks of chiropractic therapy in 2008 and 12 weeks of physical therapy around 2007. Medications include: 1. Norco 10/325 mg 1 tab q12 hours prn pain. 2. Nabumetone 500 mg 1 tablet q12h. 3. Gabapentin 600 mg qhs. 4. Lexapro. Diagnostic studies reviewed include MRI of the lumbar spine dated 01/18/2008 revealing degenerative changes of the lower lumbar spine. L3-4 left foraminal disc protrusion with mild left foraminal narrowing. L5-S1 disc bulge with annular tear and mild bilateral foraminal narrowing. X-ray report of the lumbar spine dated 01/27/2012 revealed a thoracic levoscoliosis and there is mild dextroscoliosis. Otherwise negative lumbar spine series. No pathologic motion is seen on flexion and extension. EMG/NCS dated 02/07/2012 revealed a normal EMG and nerve conduction study of bilateral lower extremities with no evidence of peripheral neuropathy or significant lumbar radiculopathy. Medical Evaluation dated 12/04/2013 documented the patient to have complaints of right elbow pain and attributes this to prolonged typing and keyboarding. The patient was initially diagnosed with right upper extremity epicondylitis for the right elbow injury. She was prescribed physical therapy, a brace, and medication. An EMG/NCV study of the upper extremity was normal in 2009. She had a right elbow epicondylar debridement, flexor re-attachment and right ulnar nerve release performed. She then had platelet rich plasma injections into her right elbow as well as at least three steroid injections at the right elbow. A lower extremity EMG/NCS was essentially normal. From the psychological standpoint the patient reports feeling guilt with regards to her limitation in function and not being able to engage more with her children and husband. She is stressed by the

fact that she is unable to be active as she previously led a very active lifestyle which included regular biking, hiking, and going out with friends. She cannot lift or carry objects without pain. Her injury and discomfort prevent her from walking more than a quarter mile. She has difficulty performing light work for more than a few minutes to one hour. She has difficulty with repetitive motions such as typing or using a computer. Her sleep is disturbed and sexual activity is less frequent because of her injury. Overall, she appears to be somewhat socially isolated. Objective findings on exam included neurological exam showing strength is full in the bilateral upper and lower extremities. Reflexes are symmetric at the bilateral biceps, patellar and Achilles tendons. Musculoskeletal examination of the spine reveals normal spinal curvatures without any scoliosis. Palpation of the lumbosacral junction is mildly tender. There is tenderness over the paraspinal muscles bilaterally. Flexion of lumbar spine is limited to 45 degrees, extension is limited to 10 degrees and lateral tilt was limited by 25% bilaterally. Examination of the right elbow revealed surgical scar over the medial aspect of the right elbow, palpation of the scar was tender. Negative Tinel's at the cubital tunnel. Note, there is significant pain inhibition on exam. Diagnoses: 1. Pain disorder associated with both a general medical condition and psychological factors. 2. Depressive disorder. 3. Anxiety disorder. 4. Axis V: Psychological problems-loss of job, loss of hobbies, financial difficulties, and increased social isolation. Discussion: The patient would very much like to improve functional abilities and pain management skills so that she can return to gainful employment and increase her engagement with work, her family, community, and li

IMR ISSUES, DECISIONS AND RATIONALES

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

160 hours of Function Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, and functional restoration programs Page(s).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, and functional restoration programs Page(s): 30-32, and 48.

Decision rationale: According to the CA MTUS guidelines, FRPs is recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria which include (1) an adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. The medical records document the patient was diagnosed with upper epicondylitis of the right elbow and underwent right elbow epicondylar debridement, flexor reattachment and

right ulnar nerve release, platelet rich plasma injection in the right elbow, and 3 steroid injections in the right elbow. The patient also complains of low back pain without significant objective findings. The patient had 12 sessions of acupuncture, 6 weeks of chiropractic therapy in 2008, and 12 weeks of PT in 2007, ESIs performed at L3-L4, and L5-S1 dated 10/15/2001 provided no benefit. While the patient does have several of the requirements for FRP's, the guidelines recommend the treatment duration for no longer than 2 weeks, 160 hours of FRPs is more than 2 weeks. Further, it is not clear if the patient is a candidate for any further surgical intervention, the request is not medically necessary according to the guidelines.