

Case Number:	CM14-0001960		
Date Assigned:	01/24/2014	Date of Injury:	07/21/2011
Decision Date:	06/06/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	01/06/2014

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 Anesthesia, has a subspecialty in Acupuncture & Pain Medicine, 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:

A 49 year old female injured worker with date of injury 7/21/11 with related pain in right radial forearm and wrist. Per 11/21/13 progress report, pain radiated down to the base of the right thumb. Intermittent numbness/tingling of all right digits and over right radial/dorsal wrist was noted. She had difficulty with heavy lifting due to right arm pain. Pain increased with typing and writing. She had increasing difficulty lifting the right arm above shoulder level, and stiffness in the right trapezius and occasionally in the right neck. She has become increasingly frustrated, depressed, and worried regarding her lack of improvement in her chronic pain condition. She was diagnosed with right radial wrist tendinitis; right de Quervain's tendinitis; right radial forearm contusion; myofascial pain in right trapezius and suspected right shoulder adhesive capsulitis. MRI of the right wrist dated 2/17/12 revealed 5mm diameter volar ganglion cyst over palmar aspect of trapezius; fluid deep in snuffbox, deep to the first compartment tendons. She has been treated with physical therapy and medication management. The date of UR decision was 12/13/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

FUNCTIONAL RESTORATION PROGRAM FOR 160 HOURS ,QUANTITY :160:00:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 30-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 30-32. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), General use of multidisciplinary pain management programs.

Decision rationale: With regard to chronic pain programs, MTUS CPMTG states "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 outlined below." The criteria for the general use of multidisciplinary pain management programs are as follows: "(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 of 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" (there are many of these outlined by the MTUS). Review of the submitted documentation indicates that the injured worker has already undergone initial evaluation and multidisciplinary conference at the [REDACTED] Functional Restoration Program. Per that evaluation, it was determined that the injured worker has not been able to functionally improve to any significant degree despite treatments to date. The injured worker meets the criteria for the use of an FRP, however we must consult ODG for specific guidance as the MTUS is silent on duration of initial trial, per ODG guidelines for the general use of multidisciplinary pain management programs: (10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis. Total treatment duration may be 160 hours, but the documentation provided does not include evidence of functional improvement that warrants authorization of the maximum treatment. The request is not medically necessary. It should be noted that the UR physician has certified a modification of this request for 60 hours of Functional Restoration Program.