

<b>Case Number:</b>	CM14-0105324		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	03/05/2013
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	06/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2014

### 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 Physical Medicine and Rehabilitation, 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:

The injured worker is a 72-year-old male who reported injury on 03/05/2013. The mechanism of injury was not submitted in review. The injured worker has diagnoses of status post left wrist surgery, status post left elbow surgery, left elbow pain, left wrist pain, left upper extremity neuritis, left upper extremity neuropathy, and fracture of the distal radius. Past medical treatments consist of surgery, physical therapy and pain medication. The submitted report did not indicate what type of medications the injured worker was on. The report submitted for review indicated a urinalysis was obtained on 04/15/2014. The injured worker underwent left wrist surgery and left elbow surgery. On 06/06/2014, the injured worker complained of constant left hand pain. Physical examination revealed that the injured worker had decreased grip strength on the left. On exam of the left elbow, he had tenderness to palpation of the medial epicondyle. The injured worker had limited range of motion secondary to pain. He was positive for Tinel's at the medial epicondyle. Examination of the left wrist revealed muscle atrophy. The injured worker had limited range of motion secondary to pain. There was hypoesthesia in the ulnar pattern. The injured worker was positive for carpal tunnel Tinel's. He had full range of motion of the digits. The plan is to get the injured worker back to modified duty to work. In order to do so, the provider feels a supervised function restoration program of 6 weeks with 1 session a week for the left elbow/left wrist is necessary. The request for authorization was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Supervised Functional Restoration Program 1xwk X 6wks Left Elbow/Left Wrist 97545:**  
Upheld

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

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

**Decision rationale:** The California MTUS states that an adequate and thorough evaluation needs to be made, including baseline functional testing, so that follow-up with the same test can note functional improvement. Criteria is as followed: previous methods of treating chronic pain have been unsuccessful; there is an absence of other options likely to resolve in significant clinical improvement; the injured worker had a significant loss of the ability to function independently resulting from the chronic pain; the injured worker was not a candidate where surgery or other treatments would clearly be warranted and the injured worker exhibited motivation to change. Negative predictors of success should also be addressed. Functional restoration treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The total treatment duration should generally not exceed 20 full day sessions and a treatment duration in excess of 20 sessions requires a clear rationale for the specific extension and reasonable goals to be achieved. There was a lack of measurable baseline against which to measure the efficacy of a functional restoration program. Additionally, there was a lack of evidence that the injured worker had failed conservative treatment, to include physical medicine and medication therapy. There was also a lack of documentation of other treatments that the injured worker underwent previously and the measurement of progress as well as the efficacy of the prior treatments. As such, the request for supervised functional restoration program is not medically necessary.