

<b>Case Number:</b>	CM14-0020080		
<b>Date Assigned:</b>	04/30/2014	<b>Date of Injury:</b>	02/15/2012
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2014

### 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 and is licensed to practice in Texas. 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 42 year old male whose date of injury is 02/15/2012. Medical evaluation dated 07/15/13 indicates that he was coming down a flight of stairs when he jammed his right ankle and twisted it on 01/01/12. He reported cumulative trauma injury to the right greater than left hand in mid-February 2012. Treatment to date includes cortisone injection to the right ankle, chiropractic care, physical therapy, acupuncture, and medication management. Impression is right ankle sprain/strain with synovitis, and repetitive stress injury bilateral hands, wrists and forearms. The injured worker is permanent and stationary with 12% whole person impairment. Psychiatric consultation dated 12/24/13 indicates that the injured worker has resigned from his job. The injured worker was diagnosed with depressive disorder, not otherwise specified. Initial evaluation dated 01/15/14 indicates that current medication is Voltaren gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FUNCTIONAL RESTORATION PROGRAM 160 HRS.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CHRONIC PAIN PROGRAMS Page(s): 30-32.

**Decision rationale:** Based on the clinical information provided, the request for a 160 hour functional restoration program is not medically necessary. According to the California MTUS guidelines, functional restoration programs are suggested for a maximum of 2 weeks (80 hours) unless there is evidence of demonstrated efficacy as documented by subjective and objective gains. In this case, the request for a 160 hour program exceeds the guideline recommendation. The injured worker presents with significant psychological issues and has been recommended for psychological treatment; however, there is no indication that the injured worker has completed this recommended treatment. The injured worker is not currently taking any opioid or psychotropic medications. Based on the guidelines and a review of the documentation provided, the requested functional restoration program is not medically necessary or appropriate.