

Case Number:	CM14-0040514		
Date Assigned:	06/20/2014	Date of Injury:	02/28/2003
Decision Date:	07/18/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/10/2014

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 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:

This 64 year-old female patient sustained an injury on 2/28/2003 while employed by. Request under consideration include 1 Functional restoration program evaluation. Reports from the provider (1/18/13; 6/10/13; 1/3/14) indicate the patient continues to treat for chronic ongoing left knee, right hip, and lower back pain radiating to left knee. The patient is reported unable to function at baseline of 60% of normal. Any standing or walking greater than 5-8 minutes worsens the pain rated at 8/10 level. The patient has past medical history of diabetes mellitus type 2, hypertension, and arthritis. Medications list Gabapentin, Metformin, Simvastatin, Januvia, Lisinopril, and Actos 30 mg qd. Conservative care over the years have included multiple injections, surgery (knee surgery 9/11/13), medications, and over 24 sessions of physical therapy and chiropractic care without any functional benefit or decrease in pain complaints. Noted exams are essentially identical and show unchanged pain on palpation of right trochanteric bursa, diffuse decreased sensation to light touch in medial and lateral aspect of left knee; tight hamstrings; without specific neurological deficits identified. Diagnoses are unchanged and list Ongoing chronic left knee pain s/p knee replacement surgery; Neuropathic pain; and Left pes anserine bursitis. The request has been previously denied in November of 2013. The current request for 1 Functional restoration program evaluation was non-certified on 2/28/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Functional restoration program evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN PROGRAMS (FUNCTIONAL RESTORATION PROGRAMS) Page(s): 30-34, 49.

Decision rationale: This 64 year-old female patient sustained an injury on 2/28/2003 while employed by. Request under consideration include 1 Functional restoration program evaluation. Reports from the provider (1/18/13; 6/10/13; 1/3/14) indicate the patient continues to treat for chronic ongoing left knee, right hip, and lower back pain radiating to left knee. The patient is reported unable to function at baseline of 60% of normal. Any standing or walking greater than 5-8 minutes worsens the pain rated at 8/10 level. The patient has past medical history of diabetes mellitus type 2, hypertension, and arthritis. Medications list Gabapentin, Metformin, Simvastatin, Januvia, Lisinopril, and Actos 30 mg qd. Conservative care over the years have included multiple injections, surgery (knee surgery 9/11/13), medications, and over 24 sessions of physical therapy and chiropractic care without any functional benefit or decrease in pain complaints. Noted exams are essentially identical and show unchanged pain on palpation of right trochanteric bursa, diffuse decreased sensation to light touch in medial and lateral aspect of left knee; tight hamstrings; without specific neurological deficits identified. Diagnoses are unchanged and list Ongoing chronic left knee pain s/p knee replacement surgery; Neuropathic pain; and Left pes anserine bursitis. The request has been previously denied in November of 2013. The current request for 1 Functional restoration program evaluation was non-certified on 2/28/14 citing guidelines criteria and lack of medical necessity. Guidelines criteria for a functional restoration program requires at a minimum, appropriate indications for multiple therapy modalities including behavioral/ psychological treatment, physical or occupational therapy, and at least one other rehabilitation oriented discipline. Criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; A level of disability or dysfunction; No drug dependence or problematic or significant opioid usage; and A clinical problem for which a return to work can be anticipated upon completion of the services. There is no report of the above as the patient has unchanged chronic pain symptoms and clinical presentation, without any aspiration to return to work for this chronic 2003 injury and has remained not working, on chronic medication without functional improvement from extensive treatments already rendered or demonstrated motivation to return to any modified work. There is also no psychological evaluation documenting necessity for functional restoration program. The 1 Functional restoration program evaluation is not medically necessary and appropriate.