

<b>Case Number:</b>	CM14-0072762		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	12/06/2012
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	04/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/20/2014

### 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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 47 year old female employee with date of injury of 12/6/2012. A review of the medical records indicates that the patient is undergoing treatment for left wrist dorsal ganglion cyst and TFC tear with evidence of scapholunate ligament partial tear on MRI. Chronic low back pain with suspected left lumbar radiculopathy; chronic cervical strain with suspected left cervical radiculitis without evidence of significant disc herniation or neuroforaminal stenosis on MRI; chronic pain syndrome; myofascial pain on the left side of neck and upper back; possible left carpal tunnel syndrome with negative electrodiagnostic studies and pain related insomnia. Subjective complaints include chronic neck, low back and left upper extremity pain; swelling in left foot and right; numbness along her left hand; headaches and dizziness. She can ambulate without assistance but has difficulty with prolonged walking and sitting. She believes that the increase in Topamax has increased her dizziness and does not improve symptoms. Objective findings include, on exam, she had tenderness over the posterior cervical paraspinal muscles on the left approximately C4-C7. She had mild limitation in cervical flexion and lateral tilt. There is tenderness to the left trapezius and left medial border of the scapula at the superior aspect. She has well preserved ROM of the shoulder but has pain in the left trapezius. MRI performed on 2/13/14 revealed: AT L5-S1, 2 mm left paracentral disc protrusion with a high intensity zone/annular fissure. Mild left neural foraminal narrowing which is front back from facet hypertrophy; at L4-L5, 2 mm annular disc bulge with high intensity zone/annular fissure; the central canal is patent. EMG/NCV performed on 3/17/14 revealed no myopathy, no polyneuropathy, no lumbrosacral plexopathy. Treatment has included physical therapy and a functional restoration program. Medications include Fluoxetine-prozac, Lidoderm 5% patch, Topiramate-topamax, Prozac and Buprenorphine. The utilization review dated 4/25/2014 non-

certified the request for [REDACTED] Functional Restoration Program X 80 additional hours.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**[REDACTED] Functional Restoration Program X 80 additional hours: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs Page(s): 49.

**Decision rationale:** MTUS states, "Long-term evidence suggests that the benefit of these programs diminishes over time", "Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." and "Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved." Medical documentation provided did not provide sufficient information to warrant certification for a full program from the initial three weeks of a functional restoration program. Treatment notes do not clearly explain the rationale for a treatment program consisting of 80 hours without providing any interim evidence of significant progress. As such, the request for [REDACTED] Functional Restoration Program X 80 hours is not medically necessary.