MAXIMUS Federal Services

Case Number:	CM14-0080043		
Date Assigned:	07/18/2014	Date of Injury:	09/23/2010
Decision Date:	12/16/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/30/2014

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 Internal 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 26-year-old woman with a date of injury of September 23, 2010. The mechanism of injury occurred as a result of constant handling of meat and twisting sausage, which caused numbness and tingling.Pursuant to a progress report dated July 1, 2011, documentation that future medical care should be left open for the injured worker`. It should include the need for follow-up appointments. Treatment should include but not limited to anti-inflammatory medications, short course of physical therapy, corticosteroid injections, acupuncture, topical analgesics, diagnostic imaging studies, nerve conduction studies, and potential surgery. Pursuant to the Primary Treating Physician's Progress Report date April 21, 2014, the injured worker` complained of ongoing pain in both upper extremities. The injured worker` did not require any pain medications at all while using the H-wave. Physical examination revealed normal range of motion in the cervical spine. There was no tenderness to palpation (TTP) over the anterior or posterior cervical triangles. There was TTP over the trapezius and interscapular area. Range of motion (ROM) of the right shoulder in forward flexion was 170 degrees, abduction at 170 degrees, and external rotation at 70 degrees. Impingement and adduction at 170 degrees, and external rotation at 90 degrees. The impingement and adduction signs were negative. ROM was normal in the in the bilateral elbows. Tinel's sign was positive at the right wrist and negative at the left wrist. Sensation was intact in all digits bilaterally. There was no evidence of thenar atrophy or interosseous muscle wasting bilaterally. There was normal ROM at the bilateral elbows. The injured worker` was diagnosed with bilateral wrist and forearm myofasciitis, bilateral medial and lateral epicondylitis, clinical right carpal tunnel syndrome, and left and right shoulder tendinitis. Reports available for review indicate only "temporary disability". No other comments regarding function are noted. The injured worker's motivation is not discussed in the medical records. The provider is recommending a Functional Restoration

Program. Reason for request: The injured worker is not a surgical candidate at this time, yet still requires prudent management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program (FRP): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 31-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program Page(s): 31-32. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Functional Restoration Program

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, the functional restoration program (FRP) is not medically necessary. The guidelines state outpatient pain rehabilitation programs may be considered medically necessary when all the following criteria are met: adequate thorough evaluation has been made, including baseline functional testing so follow up with the same set can note functional improvement; previous methods of treating chronic pain have been unsuccessful and the absence of other options likely to result in significant clinical improvement; the patient has a significant loss of ability to function independently resulting from the chronic pain; the patient is not a candidate for surgery or other treatments clearly be warranted. See guidelines for additional details. In this case, the injured worker is a 26-year-old the date of injury September 23, 2010. She was diagnosed with bilateral wrist and forearm myofaciitis, bilateral medial and lateral epicondylitis, clinical right carpal tunnel syndrome, left and right shoulder tendinitis. She admits to chronic pain in both upper extremities. She is using an H wave unit which gives her adequate relief that she does not require medications when using the unit. On November 13, 2013 the injured worker saw her treating physician for an evaluation for functional restoration program. Those recommendations are not in the medical record and available for review. The patient's pain is presently controlled by the H wave unit. In the absence of a thorough evaluation, including baseline functional testing the FRP is not clinically indicated. Additionally, the injured worker's pain is presently controlled by the H wave unit and medications are not required. Consequently, the FRP is not medically necessary. Based on the clinical information the medical record and the peer-reviewed evidence-based guidelines, the functional restoration program is not medically necessary.