

Case Number:	CM15-0100958		
Date Assigned:	06/03/2015	Date of Injury:	01/10/2014
Decision Date:	07/08/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	05/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, California
 Certification(s)/Specialty: Family Practice

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 49 year old female, who sustained an industrial injury on January 10, 2014. Treatment to date has included orthotics, medications, home exercise and activity modification. Currently on 4/8/2015, the injured worker complains of ongoing pain in the bilateral wrists and hands. She reports numbness and tingling in the right middle finger and on the left side of her thumb, index and middle fingers. Physical examination of the UE revealed tenderness on palpation, limited range of motion, normal sensation. The diagnoses associated with the request include repetitive strain injury, myofascial pain syndrome, bilateral wrist sprain/strain, bilateral lateral epicondylitis and possible peripheral neuropathy. The treatment plan includes a functional restoration program, and home exercise program. The medication list includes Albuterol, Hydrochlorothiazide, Tramadol, and Voltaren. Any surgery or procedures related to this injury were not specified in the records provided. The patient had received cortisone injection in hand. Patient has received an unspecified number of PT visits for this injury. The patient has had X-ray of the right and left hand that revealed arhrosis. The past medical history includes asthma and HTN.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional restoration program evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 31-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page 30-32 Chronic pain programs (functional restoration programs).

Decision rationale: Request: Functional restoration program evaluation. According to the CA MTUS chronic pain medical treatment guidelines chronic pain programs (functional restoration programs) are "Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below." In addition per the cited guidelines "Criteria for the general use of multidisciplinary pain management programs. Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (6) Negative predictors of success above have been addressed." Currently on 4/8/2015, the injured worker complains of ongoing pain in the bilateral wrists and hands. She reports numbness and tingling in the right middle finger and on the left side of her thumb, index and middle fingers. Physical examination of the UE revealed tenderness on palpation, limited range of motion. The diagnoses associated with the request include repetitive strain injury, myofascial pain syndrome, bilateral wrist sprain/strain, bilateral lateral epicondylitis and possible peripheral neuropathy. The patient had received cortisone injection in the hand. Patient has received an unspecified number of PT visits for this injury. The patient has had X-ray of the right and left hand that revealed arthrosis. The past medical history includes asthma and HTN. The pt has chronic pain beyond the expected time for recovery. She is on multiple medications. An initial one time EVALUATION to determine the necessity of a chronic pain management program is deemed medically appropriate and necessary in this patient at this time. The request for Functional restoration program EVALUATION is medically necessary and appropriate for this patient.