

<b>Case Number:</b>	CM15-0102570		
<b>Date Assigned:</b>	06/04/2015	<b>Date of Injury:</b>	05/27/2010
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 60 year old male who sustained an industrial injury on 05/27/2010. Mechanism of injury was not documented but he injured his small finger and suffered a fracture dislocation. Diagnoses include status post right fifth finger avulsion fracture, status post right carpal tunnel and right trigger finger release, persistent pain and sensory alteration of the right hand and forearm and myofascial pain syndrome. Treatment to date has included diagnostic studies, surgery, medications, and a home exercise program. Right hand x ray done on 09/24/2014 revealed slight early degenerative joint disease of the right thumb and fingers. A right wrist x ray done on 09/24/2014 showed arterial calcifications. A right forearm x ray done on 09/24/2014 revealed calcific tendinitis at the triceps tendon insertion at the right olecranon. Right shoulder x ray was unremarkable. The most recent physician progress note in the documentation presented was dated 02/20/2015 documents the injured worker complains of increased right hand pain. Voltaren gel usually provides approximately 50% relief but he did not receive the medications. There has been no change in his pain. He takes Gabapentin 300mg three times a day and Tramadol 50mg 1-2 a day which reduces his pain level from 8 out of 10 to 5 out of 10 and increases his functionality. Treatment requested is for Multidisciplinary evaluation. Notes indicate that the patient has previously undergone a multidisciplinary evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Multidisciplinary evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 30-34 and 49 of 127.

**Decision rationale:** Regarding the request for a functional restoration program, California MTUS supports chronic pain programs/functional restoration programs when: Previous methods of treating chronic pain have been unsuccessful and there is an 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 where surgery or other treatments would clearly be warranted; The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success above have been addressed. Within the medical information available for review, there is no documentation that an adequate and thorough evaluation has been made including baseline functional testing, no statement indicating that other methods for treating the patient's pain have been unsuccessful, no statement indicating that the patient has lost the ability to function independently, and no statement indicating that there are no other treatment options available. Additionally, there is no discussion regarding motivation to change and negative predictors of success. Additionally, it appears the patient may have undergone a previous multidisciplinary evaluation, and it is unclear what the outcome of that evaluation was. In the absence of clarity regarding the above issues, the currently requested functional restoration program is not medically necessary.