

Case Number:	CM15-0131276		
Date Assigned:	07/17/2015	Date of Injury:	01/10/2013
Decision Date:	08/17/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/07/2015

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 30 year old female who sustained an industrial /work injury on 1/10/13. She reported an initial complaint of bilateral wrist/hand pain (L>R), cervical region, low back, knee, shoulder, and bilateral leg pain. The injured worker was diagnosed as having left medial epicondylitis, chronic pain syndrome, bilateral carpal tunnel release, lumbar disc displacement, fibromyositis, fibromyalgia, right S1 radiculopathy, left wrist/hand tendinitis, left shoulder tendinitis, and psychic factors associated with diseases. Treatment to date includes medication, diagnostics, physical therapy, acupuncture, psychosocial evaluation, and home exercise program. Currently, the injured worker complained of bilateral wrist and hand pain rated 5/10, cervical, low back, knee, shoulder, and bilateral leg pain. Per the therapy report on 6/1/15, the wrist/hand pain was noted with weakness, numbness, tingling, and swelling, ambulated without an assistive device with limited speed, limited with activities of daily living (ADL's), abnormal habitual posture, unrestricted range of motion in the upper extremities with pain limiting cervical and lumbar range of motion, decreased strength is present on manual testing regarding the right calf only, movement is guarded, no sensory changes, reflexes are intact, and balance is normal. The requested treatments include 10-day functional restoration program (FRP) for the left arm. A multidisciplinary pain management evaluation dated June 1, 2015 indicates that the patient has failed acupuncture, physical therapy, medication, and surgery. The patient continues to have major functional deficits. She has ongoing neurologic deficits and psychological coping strategy issues. The patient is noted to have a strong level of motivation and positive participation.

IMR ISSUES, DECISIONS AND RATIONALES

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

10 day functional restoration program (FRP) for the left arm: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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; and Negative predictors of success above have been addressed. Within the documentation available for review, it appears that a thorough evaluation has been made, the patient has failed other treatment options including surgery, and there are no other options available. Additionally, the patient appears to have motivation to change, and negative predictors of success have been discussed. Furthermore, the request is for a 2-week trial, as supported by guidelines. Therefore, the currently requested functional restoration program is medically necessary.