

<b>Case Number:</b>	CM15-0183809		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	01/22/2015
<b>Decision Date:</b>	10/29/2015	<b>UR Denial Date:</b>	09/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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: Arizona, 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 53 year old female, who sustained an industrial injury on 1-22-2015. The injured worker is being treated for repetitive strain injury and right carpal tunnel syndrome. Treatment to date has included diagnostics, modified work, medications, physical therapy and acupuncture. Per the Primary Treating Physician's Progress Report dated 8-26-2015, the injured worker reported right upper extremity pain with numbness below elbow. She reported severe pain from the neck to the entire right upper extremity and left forearm to hand. She has had right forearm swelling for a week. She wears a right splint as needed. Objective findings included diffuse right hand and wrist tenderness with full ranges of motion. There was diffuse tenderness of the right elbow with full range of motion with complaints of pain. Work status was modified. The plan of care included medications, wrist brace, home exercise, and transfer of care to a [REDACTED] program. On 9-04-2015, Utilization Review non-certified the request transfer of care to a [REDACTED] program citing MTUS guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transfer of care to a [REDACTED] program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Chronic pain programs (functional restoration programs), Chronic pain programs, early intervention.

**Decision rationale:** According to the guidelines, 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; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. In this case, there is not a significant loss of function. The claimant does not want to undergo therapy due to pain. There is not an indication for motivation to change. The request for the trial of a functional restoration program (██████) is not medically necessary.