

Case Number:	CM15-0194481		
Date Assigned:	10/08/2015	Date of Injury:	09/09/2013
Decision Date:	11/16/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	10/02/2015

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

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 34 year old male who sustained an industrial injury on 9-9-2013. A review of medical records indicates the injured worker is being treated for complex tendon laceration with likely adhesions of the right EPB and APl tendons with right superficial radial nerve injury and subsequent dysesthesias, chronic pain syndrome, and pain related insomnia. Medical records dated 8-20-2015 noted right radial wrist pain radiating into the right dorsal hand status post laceration and surgical repair. Physical examination noted dysesthesias and allodynia to light touch over the dorsal aspect of the right hand in a superficial radial nerve distribution. He had limitation in the ability to oppose the thumb, which was limited to 40-50% normal. He had difficulty with right thumb flexion and abduction. There was limitation in the right wrist including extension and flexion to approximately 30 degrees. Radial and ulnar deviation was minimal. Treatment has included surgery and therapy. Utilization review form dated 9-4-2015 non-certified Functional Restoration Program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program 160 hours: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

Decision rationale: Review indicates the patient is s/p upper extremity surgery and continues to treat for chronic pain. He has not worked since 2013 and only currently takes over the counter Tylenol and it is not clear if he participates in or has attained any functional benefit from any current active independent exercise program. Recent psychological testing showed very minimal score for depression and anxiety to support any psychological intervention. Guidelines criteria for a functional restoration program requires at a minimum, appropriate indications for multiple therapy modalities including behavioral/psychological treatment, physical or occupational therapy, and at least one other rehabilitation oriented discipline, not seen here. Criteria for the provision of such services should include satisfaction of the criteria for coordinated functional restoration care as appropriate to the case; A level of disability or dysfunction; No drug dependence or problematic or significant opioid usage; and a clinical problem for which a return to work can be anticipated upon completion of the services. There is no report of the above as the patient has unchanged chronic pain symptoms and clinical presentation without failure from conservative treatment rendered. There are also no severe psychological issues demonstrated or evaluation documenting medical necessity for a functional restoration program. The [REDACTED] [REDACTED] Functional Restoration Program 160 hours is not medically necessary and appropriate.