

<b>Case Number:</b>	CM15-0056779		
<b>Date Assigned:</b>	04/17/2015	<b>Date of Injury:</b>	04/24/2014
<b>Decision Date:</b>	05/18/2015	<b>UR Denial Date:</b>	02/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2015

### 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: New York, Tennessee  
 Certification(s)/Specialty: Emergency Medicine

### 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 58 year old male, who sustained an industrial injury on 4/24/14. He reported right lower leg pain. The injured worker was diagnosed as having right leg pain. Treatment to date has included acupuncture that was not helpful and 6 physical therapy sessions that were noted to be partially effective. Currently, the injured worker complains of right leg pain. The treating physician requested authorization for a functional restoration program initial assessment and a computed tomography arthrogram of the right lower extremity with contrast. The computed tomography scan was recommended to rule out a meniscal tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional restoration program initial assessment:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain, Chronic pain programs (functional restoration programs).

**Decision rationale:** Functional restoration programs (FRPs) are recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. (FRPs) are interdisciplinary pain programs and emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Criteria for outpatient FRP include chronic pain syndrome, failure of previous methods to treat chronic pain, documentation that the patient has motivation to change, and evaluation by an addiction clinician if substance abuse issues are a concern. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. In this case, there is no documentation that the patient is motivated to change. Criteria for FTP have not been met. The request should not be authorized.

**CT right lower extremity arthrogram with contrast:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/22447237>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed22447237>.

**Decision rationale:** MR and CT arthrography are important imaging modalities for the assessment of the knee in certain situations. Indications for MR arthrography of the knee include assessment of the postoperative meniscus, the presence of chondral and osteochondral lesions, and the presence of intra-articular bodies. The major indication for CT arthrography is evaluating suspected internal derangement in patients who are unable to undergo MRI. In this case, documentation in the medical record does not support suspicion of internal derangement of the right lower extremity. There is normal muscle strength in bilateral lower extremities and no documented tenderness to the right knee on examination. CT arthrography of the right lower extremity is not indicated. The request should not be authorized.