

<b>Case Number:</b>	CM14-0127199		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	03/08/2013
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	07/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/11/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Medical records reflect the claimant is a 61 year old female who sustained a work injury on 3-8-13. Office visit on 7-2-14 notes the claimant did not start a FRP (Functional Restoration Program) and has not been seen by [REDACTED] to discuss surgery. On exam, the claimant had tenderness at the wrist, positive Phalen's at the median nerve and Finkelstein. Range of motion was decreased. Thumb exam showed tenderness at the basal joint and there is positive grind sign. She had good range of motion. It was noted that corticosteroid injections and surgery will be considered if there is no improvement with physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Six (6) Sessions of Functional Restoration Therapy for Bilateral Upper Extremities:**

Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines FUNCTIONAL RESTORATION PROGRAM Page(s): 49.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines notes that FRP are recommended, although research is still ongoing as to how to most appropriately screen for

inclusion in these programs. Medical Records reflect this claimant is being considered for further treatment. Additionally, there is an absence in documentation noting that this claimant has undergone appropriate screening to support that she is an ideal candidate for this type of program. Therefore, the request of six (6) Sessions of Functional Restoration Therapy for Bilateral Upper Extremities is not medically necessary and appropriate.