

<b>Case Number:</b>	CM14-0099482		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	01/30/2006
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	06/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/27/2014

### 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 Emergency Medicine 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:

The injured worker is a 67-year-old female who reported an injury on 01/30/2006 due to a slip and fall on a wet floor. The injured worker has diagnoses of pain in joint, lower leg/status post left total knee arthroscopy and mononeuritis of the lower limb non-specified. Past medical treatment consists of surgery, physical therapy, medication therapy. Medications include Ketamine 5%, Lidoderm, Tramadol and Trazodone. An electromyography of the lower extremity was obtained on the injured worker. The results revealed grossly normal. In 05/2006, the injured worker underwent left knee arthroscopy surgery and underwent left knee total replacement in 05/2013. On 06/20/2014, the injured worker complained of bilateral knee pain. Examination of the left knee revealed significant tenderness to palpation and allodynia around the anterior aspect of the left knee. The injured worker had guarding with palpation. Range of motion was full with extension, but decreased by 35% with flexion. Anterior and posterior drawer tests were negative. It was difficult for the injured worker to perform medial/lateral collateral ligament stress tests secondary to guarding. Treatment plan is for the injured worker to continue with Functional Restoration Program 160 hours. The rationale and Request for Authorization form were submitted for review.

### 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 Treatment Guidelines Functional restoration programs (FRPs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs) Page(s): 30-32.

**Decision rationale:** The California MTUS state than an adequate and thorough evaluation needs to be made, including baseline functional testing, so that follow-up with the same test can note functional improvement. Previous methods of treating chronic pain have been unsuccessful, and there is an absence of other options likely to result in significant clinical improvement. If the patient had a significant loss of ability to function independently resulting from the chronic pain, the injured worker was not a candidate for surgery or other treatments would clearly be warranted and the injured worker exhibits motivation to change, are also criteria for a Functional Restoration Treatment Program. Negative predictors of success should also be addressed. Functional Restoration treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as demonstrated by subjective and objective gains. The treatment duration should generally not exceed 20 full day sessions, and treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. The submitted documents did include the functional capacity evaluation (FCE) reports of the injured worker. The FCE report dated 06/05/2014 indicated that the injured worker continued to report severe pain in the left leg that radiated from the left knee to the lateral aspect of the calf and proximally into the left lateral aspect of the thigh and left hip. FCE report dated 06/27/2014 indicated that the injured worker continued to report severe pain in the left leg to the lateral aspect of the calf and proximally into the left lateral aspect of the thigh and left hip. According to the reports submitted for review, there was no change in the injured worker from the beginning of 06/2014 to the end of 06/2014 with Functional Restoration Program. Additionally, there was also lack of evidence that the injured worker had failed conservative treatment, to include physical medicine and medications. Furthermore, there was lack of documentation of other treatments underwent previously and the measurement of progress as well as the efficacy of those prior treatments. The provider's rationale was not submitted for review. It was unclear as to how additional hours of Functional Restoration Program will help the injured worker with any functional deficits. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request for Functional Restoration Program - 160 hours is not medically necessary.