

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0015561 | | |
| Date Assigned: | 02/03/2015 | Date of Injury: | 02/21/2001 |
| Decision Date: | 03/25/2015 | UR Denial Date: | 01/13/2015 |
| Priority: | Standard | Application Received: | 01/27/2015 |

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 Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 56 year old male, who sustained an industrial injury on February 21, 2001. The diagnoses have included reflex sympathetic dystrophy of upper limb, muscle spasm and carpal tunnel syndrome. A progress note dated December 11, 2014 provides that the injured worker has some worsening of his complex regional pain syndrome with right shoulder pain and possible impingement. It is noted that all conservative therapies have been exhausted although no mention of what therapies have been employed. Recommendation is for multidisciplinary team evaluation. On January 13, 2015 utilization review non-certified a request for HELP interdisciplinary pain rehabilitation program evaluation. The Medical Treatment Utilization Schedule (MTUS) Chronic Pain guidelines were utilized in the determination. Application for independent medical review (IMR) is dated January 27, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

HELP Interdisciplinary Pain Rehabilitation Program Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program (FRP) Page(s): 30.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Functional restoration program <http://www.odg-twc.com/>

Decision rationale: According to ODG guidelines, functional restoration program Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in “Delayed recovery.” This study concluded that an interdisciplinary functional restoration program (FRP) is equally effective for patients with chronic upper extremity disorders, including the elbow, shoulder and wrist/hand, as for patients with lumbar spine disorders, regardless of the injury type, site in the upper extremity, or the disparity in injury-specific and psychosocial factors identified before treatment. (Howard, 2012) See the Chronic Pain Chapter for the specific ODG Criteria highlighted in blue, for the use of multidisciplinary pain management programs. There is no documentation that the patient condition required a restoration program. There is no documentation of the outcome of previous use of functional restoration program and the need for more programs is not clear. Therefore, the request for HELP Interdisciplinary Pain Rehabilitation Program Evaluation is not medically necessary.