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| <b>Case Number:</b>   | CM15-0118233 |                              |            |
| <b>Date Assigned:</b> | 06/26/2015   | <b>Date of Injury:</b>       | 10/30/2012 |
| <b>Decision Date:</b> | 07/28/2015   | <b>UR Denial Date:</b>       | 05/27/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/18/2015 |

### 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: 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 36-year-old female, who sustained an industrial injury on 10/30/12. She reported right hand pain. The injured worker was diagnosed as having tenosynovitis of the hand and wrist, pain in joint of the hand, and chronic pain syndrome. Treatment to date has included the use of wrist braces, occupational therapy, a home exercise program, and medication including Norco, Diclofenac Sodium, and Lidopro ointment. Progress note dated 5/19/15 was reviewed along with physical exam and plan. Currently, the injured worker complains of right upper extremity pain, right wrist pain, and bilateral hand pain rated as 6/10. The treating physician requested authorization for 1 initial evaluation for a functional restoration program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 initial evaluation for functional restoration program: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Chronic Pain Programs.

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

**Decision rationale:** As per MTUS Chronic pain guidelines, certain criteria should be met before recommendation to a program. It requires A functional baseline testing to measure baseline improvement. Meets criteria. Failure of prior chronic pain treatment. Fails criteria. There is no proper documentation of prior chronic management plan or conservative therapy attempted prior to FRP request. Documentation states that patient had occupational therapy done sometime in 2013 but patient has generally avoided physical activity due to pain. There is no documentation of any recent physical therapy and patient is taking very limited amount of pain medications. Loss of function due to pain. Meets criteria. Not a candidate for surgery. Fails criteria. Provider has documented that the refusal for injections or surgery is patient's preference and is not due to medical indication. Motivation to change. Meets criteria. Negative predictors for success has been addressed. Meets criteria. Patient has yet to fail conservative therapy and the general lack of any intervention or surgical interventions does not meet criteria. Functional Restoration Program is not medically necessary.