

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0092687 | | |
| Date Assigned: | 05/19/2015 | Date of Injury: | 03/09/2001 |
| Decision Date: | 06/19/2015 | UR Denial Date: | 04/17/2015 |
| Priority: | Standard | Application Received: | 05/13/2015 |

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 67 year old female, who sustained an industrial/work injury on 3/9/01. She reported initial complaints of bilateral hand pain. The injured worker was diagnosed as having left hand strain injury, myofascial pain syndrome, carpal tunnel syndrome, left second and third digit trigger finger, and flare up of left hand pain with left ganglion cyst. Treatment to date has included medication, surgery (carpal tunnel release surgery and digit release of 2nd and 3rd digit trigger finger on 1/22/09). Currently, the injured worker complains of right hand pain. Per the primary physician's progress report (PR-2) on 4/7/15, examination noted decreased bilateral wrist and hand strength with well healed surgical scar in the wrist along with decreased shoulder range of motion and strength. Current plan of care included medication and functional restoration program. The requested treatments include Functional Restoration Program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, Chapter 7, page 127.

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

Decision rationale: The patient in this case has a long-standing history of pain, and a request has been made for use of a functional restoration program. The MTUS thoroughly discusses recommendations and indications for use of functional restoration programs. The provided documents do not clearly show evidence of failed treatment modalities, and while it appears that the patient is not a candidate for surgery, objective findings in the provided documents are scant and non-specific. The first criterion of the MTUS is a thorough baseline evaluation so that evidence of functional improvement with treatment is clear, and in this case, the baseline function is not clearly documented on objective exam. While a functional restoration program may be a treatment modality for future consideration, based on the current guidelines and the provided case documents, implementation of a functional restoration program at this time is not considered medically necessary.