

<b>Case Number:</b>	CM13-0040543		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	01/07/2012
<b>Decision Date:</b>	02/27/2014	<b>UR Denial Date:</b>	10/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Oklahoma and 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 physician 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 patient is a 66-year-old male who reported injury on 01/07/2012. The mechanism of injury was stated to be the patient was lifting a large area rug when he felt a pop and pain in his left shoulder. The patient was noted to undergo physical therapy, shoulder surgery, a cortisone injection, and pain medications. The patient's diagnoses were noted to include left rotator cuff tear, chronic pain syndrome, opioid dependence and depression. The request was made for an outpatient functional restoration program for 20 days and 6 monthly follow-up visits for the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient functional restoration program for 20 days and 6 monthly follow-up visits, for the left shoulder:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines indicate that the criteria for entry into a functional restoration program includes an adequate and thorough evaluation that has been made

including baseline functional testing so follow-up with the same test can note functional improvement, documentation of previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, documentation of the patient's significant loss of the ability to function independently resulting from the chronic pain, documentation that the patient is not a candidate for surgery or other treatments would clearly be warranted, documentation of the patient having motivation to change and that they are willing to forego secondary gains including disability payments to effect this change, and negative predictors of success has been addressed. Additionally it indicates the treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The clinical documentation submitted for review indicated the patient met the above criteria. However, the request, as submitted, was made for 20 days and 6 follow-up visits which would exceed guideline recommendations without re-evaluation. There was a lack of documentation with the rationale or exceptional factors to warrant exceeding guideline recommendations. Given the above, the request for outpatient functional restoration program for 20 days and 6 monthly follow-up visits, for the left shoulder is not medically necessary.