

Case Number:	CM13-0045118		
Date Assigned:	12/27/2013	Date of Injury:	09/29/2011
Decision Date:	02/27/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/01/2013

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 and Rehabilitation 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 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 57-year-old female who reported an injury on 09/29/2011. The patient was currently diagnosed with a cervical disc injury, cervical sprain/strain injury, myofascial pain syndrome, possible cervical radiculopathy, right shoulder strain injury, depression, left shoulder pain, status post right shoulder surgery on 02/21/2013, lumbosacral sprain/strain injury and right S1 lumbosacral radiculopathy. The patient was seen by [REDACTED] on 11/04/2013. The patient reported ongoing pain in multiple areas of the body. The physical examination revealed a well-healed surgical scar on the right shoulder, decreased strength and decreased range of motion. The treatment recommendations included a 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 treatment, 6 weeks, unspecified frequency: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 31-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Programs Section Page(s): 30-33.

Decision rationale: The California MTUS Guidelines state that functional restoration programs are recommended where there is access to programs with proven successful outcomes for

patients with conditions that put them at risk of delayed recovery. An adequate and thorough evaluation should be made, including baseline functional testing. There should be evidence that previous methods of treatment chronic pain have been unsuccessful, and there is an absence of other options likely to result in significant clinical improvement. As per the documentation submitted, there was no evidence of an absence of other options that were likely to result in significant clinical improvement. The patient was recently approved for a course of physical therapy on 08/21/2013 and has not been previously treated with lumbar epidural steroid injections. The patient was also issued authorization for a lumbar laminectomy in 07/2013. The patient also reported symptom improvement with recent weight loss. Based on the clinical information received, the patient does not currently meet the criteria for a functional restoration program. Therefore, the request is non-certified.