MAXIMUS Federal Services

Case Number:	CM14-0000844		
Date Assigned:	01/22/2014	Date of Injury:	06/15/2011
Decision Date:	07/08/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	01/02/2014

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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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/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:

[redacted] is a 58-year-old woman with type 2 diabetes, hypercholesterolemia, and hypertension who sustained a work-related injury on July 15, 2011. Subsequently the patient developed right shoulder and low back pain. According to a medical report dated on November 18, 2013, the patient's right shoulder pain is a constant pain that radiates to the neck. She describes it as a burning, aching, and stabbing pain. It's worse with lifting and better with rest. She does state that it is associated with weakness and numbness in the hand as well as associated with headaches. Her low back pain is also described as constant, radiating down the lateral thigh, knee, and ankle to the midfoot. It's worse with activities. Her physical examination demonstrated tenderness to palpation over the S1 joint and the paraspinal muscles, as well as the spinous processes of L5 and S1. There is diminished range of motion to extension of the lumbar spine, as well as flexion limited to 15 degrees of the lumbar spine. Her strength was limited diffusely to 4/5 on the right lower limb with hip flexion, knee extension, knee flexion, ankle dorsiflexion, ankle plantar flexion, ankle inversion, and ankle eversion, as well as extensor hallucis longus muscle groups. She also had 3/5 strength with right hip abductors. The shoulder had tenderness over the anterior part of the shoulder, as well as in the insertion of the biceps tendon. She had diminished range of motion to internal rotation of the right shoulder to 80 degrees. She had diminished range of motion to abduction at 80 degrees, diminished range of motion of the right shoulder to flexion at 120 degrees, and diminished strength of the right shoulder at 4/5 strength for internal and external rotation.Her reflexes were symmetric, although diminished at the Achilles bilaterally. She had diminished sensation to pinprick diffusely in the right limb, as well as to light touch in the right lower limb. She had misfiring of the lumbar paraspinals and the right hamstring muscles. The patient was diagnosed with low back pain, right shoulder adhesive capsulitis, right shoulder biceps tendinitis, status post right shoulder arthroscopy, trochanteric

bursitis, S1 joint dysfunction on the right, myofascial pain syndrome, and lumbar radiculitis. The patient was treated with pain medications, physical therapy, approximately 6 sessions, chiropractic therapy, approximately 6 sessions, and an epidural steroid injection. The patient was also treated with the following pain medications of undetermined duration: Hydrocodone, Neurontin and Flexeril. The provider stated the patient did not return to her independent status despite the used therapies. The provider requested authorization for 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: TWELVE (12) PART-TIMES SESSIONS: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 31-33.

Decision rationale: [redacted] approved the requested functional restoration on his review on January 14 2014. There is documentation that the patient exhausted all therapeutic options mentioned in his file. There are no psychological issues or evaluation to not support the referral to a restoration program. There is documentation that the patient exhibits motivation to go attend the restoration program. The patient is no candidate for surgery and is no looking for a secondary gain. Therefore, the request for functional restoration program: twelve (12) part-time sessions are medically necessary.