

Case Number:	CM14-0003506		
Date Assigned:	01/31/2014	Date of Injury:	10/02/2001
Decision Date:	06/23/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/08/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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:

The injured worker is a 42-year-old male who reported an injury on 10/02/2001. The mechanism of injury was not specifically stated. The current diagnoses include back syndrome, status post lumbar spine excision/fusion, depression, and left shoulder rotator cuff tear. The injured worker was evaluated on 11/07/2013. The injured worker reported 9/10 pain with numbness. The injured worker also reported insomnia, anxiety, depression, and activity limitation. Previous conservative treatment includes rest, activity modification, and heat therapy. Physical examination revealed nonspecific tenderness in the left shoulder, tenderness at the acromioclavicular joint, positive impingement testing on the left, positive apprehension testing, limited shoulder range of motion bilaterally, diminished biceps reflexes, positive straight leg raising, severe paraspinal lumbar tenderness, muscle guarding and spasm, limited lumbar range of motion, and normal deep tendon reflexes. The treatment recommendations at that time included authorization for a functional restoration program, 2 times per week for 8 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 FUNCTIONAL RESTORATION PROGRAM TWO TIMES PER WEEK FOR 8 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs.

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

Decision rationale: California MTUS Guidelines state functional restoration programs are recommended where there is access to programs with proven successful outcomes for patients with conditions that place them at risk of delayed recovery. An adequate and thorough evaluation should be made. There should be evidence that previous methods of treating chronic pain have been unsuccessful. As per the documentation submitted, there is no evidence of an adequate and thorough evaluation. There is no documentation of an exhaustion of conservative treatment. There is no indication that negative predictors of success have been addressed. The injured worker reports ongoing depression, anxiety, and insomnia. Additionally, California MTUS Guidelines state treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Therefore, the current request for a functional restoration program, twice per week for 8 weeks exceeds guideline recommendations. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary.