

Case Number:	CM14-0115746		
Date Assigned:	08/04/2014	Date of Injury:	10/18/2010
Decision Date:	09/10/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/23/2014

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 & Rehabilitation, and is licensed to practice in Illinois. 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 50-year-old female who reported an injury on 10/18/2010. The mechanism of injury was a fall. The diagnoses included cervical strain, right shoulder partial rotator cuff tear, bilateral shoulder impingement syndrome, bilateral wrist strain, TFCC tears bilateral wrists, rule out carpal tunnel syndrome bilateral upper extremities, lumbar strain, lumbar disc herniation, neuropathic pain upper and lower extremity, and bilateral knee strain. Previous treatments included medication and wrist splints. Diagnostic imaging included an MRI and EMG/NCV. Within the clinical note dated 06/03/2014, it was reported the injured worker complained of neck and right shoulder pain. She complained of wrist and back pain. The injured worker reported her bilateral knees continued to hurt. She described the pain as moderate to severe, sharp in nature. On the physical examination, the provider noted tenderness over the paracervical musculature. The injured worker had muscle spasms in the paracervical musculature. The provider noticed the injured worker had diminished sensation at C6 on the right side. The injured worker had tenderness in the paralumbar musculature with muscle spasms. The provider indicated the injured worker had a negative straight leg raise test. Upon examination of the right shoulder, the provider noted the injured worker had a positive Hawkins test and positive clicking. The provider indicated the injured worker had positive tenderness dorsally on the left wrist. The injured worker had positive patellofemoral facet tenderness on the left and right knee. The provider requested a functional restoration program; a rationale was not provided for clinical review. The Request for Authorization was submitted and dated on 06/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program candidate evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (functional restoration programs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-32.

Decision rationale: The request for functional restoration program candidate evaluation is not medically necessary. The injured worker complained of neck and right shoulder pain. She complained of bilateral knee pain. She described the pain as moderate to severe, sharp in nature. The California MTUS Guidelines recommend a functional restoration program where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk for delayed recover. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met, including: an adequate and thorough evaluation has been made, including baseline functional testing so the follow-up with the same test can note functional improvement. Previous methods of testing chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. The injured worker has significant loss of ability to function independently, resulting from chronic pain. The injured worker is not a candidate where surgery or other treatments would clearly be warranted if a goal of treatment is to prevent or avoid controversial or optional surgery of a trial of 10 visits may be implemented to assess whether the surgery may be avoided. The injured worker exhibits motivation to change and willing to forego surgery secondary gains, including disability payments, to affect this change. Negative predictors of success above have been addressed. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy, as documented by subjective and objective gains. The request submitted failed to provide the number of sessions the provider is requesting the injured worker to undergo. There is a lack of documentation indicating the provider had evaluated the injured worker with baseline functional testing. There is a lack of documentation indicating the injured worker had been unsuccessful with previous treatment methods. There is a significant lack of documentation indicating the injured worker had significant loss of ability to function independently resulting from chronic pain. Therefore, the request is not medically necessary.