

Case Number:	CM14-0122589		
Date Assigned:	09/29/2014	Date of Injury:	04/05/2013
Decision Date:	11/05/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/04/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 76-year-old female with a reported injury on 04/05/2013. The mechanism of injury was not noted in the records. The injured worker's diagnoses included chest contusion, thoracic sprain/strain, and myofascial pain. The past treatments included pain medication. There was no diagnostic imaging submitted for review. There was no surgical history documented in the notes. The subjective complaints on 07/08/2014 included neck and right shoulder pain. The objective physical exam findings were documented as effective movement, appropriate. The injured worker's medications included LidoPro and Menthoderm topical ointment. The treatment plan was to order physical therapy and a functional restoration program. A request was received for physical therapy times 6 to the right shoulder and for functional restoration times 6. The rationale for the request was for instructions for a home exercise program and the rationale for the functional restoration was to help the injured worker get back to work. The Request for Authorization form was dated 07/08/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

PT x 6 to the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The California MTUS Guidelines state up to 10 visits of physical therapy may be supported for unspecified myalgia and continued visits should be contingent on documentation of objective improvement. The injured worker has chronic back pain. However, there was no clear documentation of functional deficits i.e. decreased range of motion or decreased motor strength in the physical examination. In the absence of functional deficits, the request is not supported by the evidence based guidelines. The request for PT x 6 to the right shoulder is not medically necessary.

Functional restoration x6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs) Page(s): 49.

Decision rationale: The California MTUS Chronic Pain Guidelines state that admission to a functional restoration program may be appropriate when an adequate and thorough multidisciplinary evaluation has been performed and baseline functional testing has been completed. Additionally, documentation should show that previous treatment methods have been unsuccessful and there is an absence of other options, including surgery, likely to result in significant clinical improvement; the patient has significant difficulty functioning independently; the patient has motivation to change; and negative predictors of success have been addressed. When indicated, treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains, and the total treatment duration should generally not exceed 20 full-day sessions or the equivalent in part-day sessions. The injured worker has chronic pain. There was no multidisciplinary evaluation submitted with in the clinical notes. In the absence of this evaluation is it not clear if the injured worker meets the criteria for a functional restoration program. The request for Functional restoration x6 is not medically necessary.