

Case Number:	CM14-0079729		
Date Assigned:	07/18/2014	Date of Injury:	06/11/2012
Decision Date:	08/26/2014	UR Denial Date:	05/01/2014
Priority:	Standard	Application Received:	05/30/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Florida. 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 patient is a 57 year old who was injured on 6/11/2012. The diagnoses are right shoulder pain and status post right shoulder surgery. The past surgery history is significant for right shoulder rotator cuff tear and greater tuberosity avulsion repair on 6/11/2013. On 4/9/2014, [REDACTED] noted subjective complaints of mild shoulder discomfort with a pain score of 3-4/10. The patient reported that she is able to accomplish selfcare with no increase in pain. Examination did show a very little decrease in range of motion but no tenderness. [REDACTED] noted that the patient had completed PT and had progressed to home exercise program. The medications are tramadol for pain and Ambien for sleep. The patient had a Psychological Evaluation on 4/9/2014. A Utilization Review determination was rendered on 5/1/2014 recommending non certification for Functional Restoration Program x2 weeks (10 days).

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional restoration program two (2) times a week for ten (10) day for the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-34.

Decision rationale: The MTUS addressed the use of functional restoration programs in the treatment of chronic pain. The beneficial effects include an increase in range of motion, improved activities of daily living (ADL) and reduction in utilization of medications and health/support services. The records indicates that the patient reported minimal pain of 3-4/10 and minimal effects on range of motion/ADL on 04/09/2014. There was no tenderness on the affected right shoulder. The patient had completed physical therapy and had progressed to a home exercise program. The criteria for potential beneficial effects from a functional restoration program were not met. Therefore, this request is considered not medically necessary.