

Case Number:	CM14-0088648		
Date Assigned:	07/23/2014	Date of Injury:	10/01/2011
Decision Date:	08/27/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/12/2014

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 54-year-old female who reported an injury on 10/01/2011. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included a physical therapy, chiropractic care, medication therapy, and multiple epidural steroid injections. The injured worker was evaluated on 03/25/2014. Objective findings included limited range of motion secondary to pain with trigger points palpated in the paraspinal musculature of the lumbar spine. It was noted that the injured worker had a positive straight leg raising test bilaterally. Evaluation of the right shoulder revealed restricted range of motion secondary to pain with +3 tenderness to palpation of the acromioclavicular joint. The injured worker's diagnoses included lumbar myospasms, lumbar pain, lumbar sprain/strain, right rotator cuff tear, right shoulder impingement, right shoulder pain, and right shoulder sprain/strain. The injured worker's treatment plan included 12 sessions of work conditioning, additional chiropractic care, and additional localized intense neurostimulation therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Work conditioning twelve (12) sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning Page(s): 125-126.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, work hardening, page(s) 125 Page(s): 125.

Decision rationale: California Medical Treatment Utilization Schedule recommend up to 10 sessions of work conditioning as appropriate treatment in the management of chronic pain. The requested 12 sessions exceeds this recommendation. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Additionally, the results of previous physical therapy was not provided to support the need for more intensive work conditioning sessions. Furthermore, the request as it is submitted does not specifically identify a body part for treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested work conditioning 12 sessions is not medically necessary.

Final functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 137-138, Chronic Pain Treatment Guidelines ODG, Functional capacity evaluation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The American College of Occupational and Environmental Medicine recommend a Functional Capacity Evaluation when a more precise delineation of the injured worker's functional capabilities is needed to determine the injured worker's ability to participate in normal job duties when this cannot be determined by a more traditional physical evaluation. The clinical documentation submitted for review does not provided any evidence that the injured worker is at or near maximum medical improvement and has had failed return to work attempts. Therefore, the need for a Functional Capacity Evaluation is not supported. As such, the requested final Functional Capacity Evaluation is not medically necessary.