

Case Number:	CM14-0091977		
Date Assigned:	07/25/2014	Date of Injury:	11/16/2011
Decision Date:	09/26/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/18/2014

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 and is licensed to practice in Nevada. 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 records presented for review indicate that this 49-year-old was reportedly injured on November 16, 2011. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated May 5, 2014, indicates that there are ongoing complaints of bilateral shoulder, wrist, and hand pain as well as right elbow pain. The physical examination demonstrated tenderness and decreased range of motion of the cervical spine. There was a positive foraminal compression test and a normal upper extremity neurological examination. There was tenderness at the right elbow and a positive bilateral Finkelstein's test. Diagnostic imaging studies of the cervical spine showed a disc herniation at C4 - C5 with cervical spinal stenosis. An MRI the lumbar spine showed a disc herniation at L5 - S1 which abuts the descending S1 nerve root bilaterally. An MRI the right shoulder showed a type I acromion and mild tendinitis of the supraspinatus tendon. Previous treatment includes physical therapy, oral medications, and activity modification. A request had been made for a functional restoration multidisciplinary candidate evaluation and physical therapy once a week for eight weeks for the bilateral shoulders and wrists and was not certified in the pre-authorization process on June 2, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Multidisciplinary Candidate Evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 30-34 of 127.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines the criteria for participation in a multi-disciplinary pain management program includes documentation that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. Additionally it should be stated that the injured employee is not a surgical candidate and that they have lost the ability to function independently as a result of chronic pain. A review of the attached medical record does not indicate that other conservative treatment methods other than physical therapy, oral medications, and activity modification would not be likely to result in improvement. It is not even clear that physical therapy has not been effective as there is a concurrent request for additional physical therapy for the shoulders and wrists. Additionally it is not stated that future surgery is not considered or that the injured employee has lost the ability to function independently. Therefore, the request for a functional restoration multidisciplinary candidate evaluation is not medically necessary or appropriate.

Physical therapy for the bilateral shoulders and wrists, once weekly for eight weeks:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201.

Decision rationale: It is unclear from the attached medical record how many visits of physical therapy the injured employee has attended thus far for the shoulders and wrists and efficacy of these sessions. Without this information additional therapy cannot be justified. As such, the request for physical therapy for the bilateral shoulders and wrists, once weekly for eight weeks, is not medically necessary or appropriate.