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| Case Number: | CM14-0204864 | | |
| Date Assigned: | 12/17/2014 | Date of Injury: | 03/23/2010 |
| Decision Date: | 02/11/2015 | UR Denial Date: | 12/02/2014 |
| Priority: | Standard | Application Received: | 12/08/2014 |

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 Internal Medicine, has a subspecialty in Hospice Palliative Medicine and is licensed to practice in Pennsylvania. 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 51-year-old woman with a date of injury of 03/23/2010. The submitted and reviewed documentation did not identify the mechanism of injury. Treating physician notes dated 11/19/2014 and 11/05/2014 indicated the worker was experiencing right shoulder pain and right elbow pain that went into the right hand. Documented examinations consistently described tenderness in the right shoulder, muscle tightness in the right upper back, tenderness in the right elbow and outer wrist, and positive Phalanx and Tinel's signs at the right elbow. The submitted and reviewed documentation concluded the worker was suffering from right shoulder rotator cuff injury and strain/sprain, myofascial pain syndrome, and possible neuropathy/right cubital tunnel syndrome. Treatment recommendations included medications, improving coping techniques, a functional restoration program, continued home exercise program, heat and cold therapy, and follow-up care. A Utilization Review decision was rendered on 12/02/2014/2014 recommending non-certification for a functional restoration evaluation. A physical therapy treatment note dated 10/23/2014 and an acupuncture treatment note dated 11/26/2014 were also reviewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Evaluation Page(s): 31-32.

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

Decision rationale: A functional restoration program (FRP) is a type of interdisciplinary pain program specifically tailored for those with chronic disabling occupational musculoskeletal disorders. The focus is to maximize function rather than eliminate pain. While additional quality research is needed, the MTUS Guidelines recommend this treatment. A two week trial is recommended with additional treatment after demonstrating both patient-reported and objective improvement. The documentation concluded the worker was suffering from right shoulder rotator cuff injury and strain/sprain, myofascial pain syndrome, and possible neuropathy/right cubital tunnel syndrome. A physical therapy treatment note dated 10/23/2014 indicated the worker's pain intensity and function had increased quite significantly with treatment, and the reviewed records reported the worker was recently transitioned to the home exercise program. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for a functional restoration evaluation is not medically necessary.