

<b>Case Number:</b>	CM14-0090342		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	05/30/2011
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 47-year-old female who sustained an industrial injury on 05/30/2011. Diagnoses include complex regional pain syndrome, cervicgia, and right shoulder acromioclavicular joint arthrosis with impingement, right shoulder rotator cuff tendinopathy and right shoulder pain. Treatment to date has included medications, physical therapy, psychological counseling, cognitive behavioral therapy, electrical stimulation, ice and heat, and injections. A physician progress note dated 05/20/2014 documents the injured worker complains of right neck and shoulder pain. Pain is constant and variable in intensity. Average pain score is 7-9 out of 10. She has right upper extremity weakness, stiffness and spasms of the neck and interference with sleep. Shoulder extension is limited in her right upper extremity, and abduction, external rotation and internal rotation is limited. She has noticeable swelling at the right trapezius, and exquisite tenderness with spasming and guarding. Treatment requested is for Functional restoration program for shoulder pain, 3 x per week for 4 weeks (for 12 visits total). On 06/06/2014 Utilization Review non-certified the request for Functional restoration program for shoulder pain, 3 x per week for 4 weeks (for 12 visits total) and cited was CA MTUS Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional restoration program for shoulder pain, 3 x per week for 4 weeks (for 12 visits total): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the general use of multidisciplinary pain management programs, and Functional restoration programs Page(s): 31-32, and 49.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 30-33.

**Decision rationale:** This patient presents with neck and right shoulder pain and right shoulder numbness. The current request is for FUNCTIONAL RESTORATION PROGRAM FOR SHOULDER PAIN 3X PER WEEK FOR 4 WEEKS FOR 12 VISITS TOTAL. The Request for Authorization is dated 4/1/14. The MTUS page 30 to 33 recommends functional restoration programs and indicates it may be considered medically necessary when all criteria are met including, 1. Adequate and thorough evaluation has been made, 2. Previous methods of treating chronic pain have been unsuccessful, 3. Significant loss of ability to function independently resulting from the chronic pain, 4. Not a candidate for surgery or other treatment would clearly be warranted, 5. The patient exhibits motivation to change, 6. Negative predictors of success above have been addressed. On 5/20/14, the treating physician stated that the patient would benefit from a multidisciplinary program to help her adjust her chronic pain and limit of activities of daily living. The Utilization review denied the request stating that there appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. The MTUS guidelines have extensive criteria for a functional restoration program and require that all of the criteria be met. The available records did not indicate the patient has loss of ability to function independently or that she is not a surgical candidate. Furthermore, an evaluation was not provided. MTUS states functional restoration programs are indicated only after adequate and thorough evaluation has been made, which address the patient's motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success above have been addressed. In this case, not all of the MTUS criteria for a functional restoration program have been met. Therefore, the request for functional restoration program IS NOT medically necessary.