

Case Number:	CM15-0100903		
Date Assigned:	06/03/2015	Date of Injury:	07/16/2012
Decision Date:	07/01/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/26/2015

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: Emergency Medicine

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 37-year-old, male who sustained a work related injury on 7/16/12. He was unloading a truck of a tree weighing between 100 and 250 pounds. He noticed immediate right shoulder and upper back pain. The diagnoses have included shoulder region disorders, pain in shoulder joint, and shoulder disorders with bursae and tendons. Treatments have included occupational therapy, physical therapy, oral medications, Terocin patches, Lidopro ointment, chiropractic treatments, massage therapy, acupuncture, right shoulder steroid injections, right shoulder surgery and home exercises. In the Visit Note, Follow-up Visit dated 4/10/15, the injured worker complains of right upper extremity pain. He rates the pain level 7/10. He describes the pain as moderate to severe, aching, cramping and throbbing. He states the medications are helping. The right shoulder range of motion is restricted with abduction. He has normal extension and extension. He has tenderness to palpation in the biceps groove and glenohumeral joint. The treatment plan includes a request for a functional restoration program evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

64 hours of functional restoration program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs, Chronic pain programs (functional restoration programs), early intervention. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Chronic pain programs (functional restoration programs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pg. 49 and Pages 31-32, Functional restoration programs (FRPs) Page(s): 31-32, 49.

Decision rationale: The requested 64 hours of functional restoration program, is not medically necessary. CA MTUS 2009 Chronic Pain Treatment Guidelines recommend a functional restoration program with satisfaction of specifically identified qualification criteria, all of which must be satisfied for approval of such a program and "Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery". The injured worker has of right upper extremity pain. He rates the pain level 7/10. He describes the pain as moderate to severe, aching, cramping and throbbing. He states the medications are helping. The right shoulder range of motion is restricted with abduction. He has normal extension and extension. He has tenderness to palpation in the biceps groove and glenohumeral joint. Satisfaction of all of these criteria is not currently documented (including non-surgical candidacy, significant functional loss, positive motivation, and addressed negative predictors of success). The criteria noted above not having been met, 64 hours of functional restoration program is not medically necessary.

Functional restoration program was recommended by 2-9-15 QME: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs, Chronic pain programs (functional restoration programs), early intervention. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Chronic pain programs (functional restoration programs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pg. 49 and Pages 31-32, Functional restoration programs (FRPs) Page(s): 49, 31-32.

Decision rationale: The requested Functional restoration program was recommended by 2-9-15 QME, is not medically necessary. CA MTUS 2009 Chronic Pain Treatment Guidelines recommend a functional restoration program with satisfaction of specifically identified qualification criteria, all of which must be satisfied for approval of such a program and "Recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery". The injured worker has of right upper extremity pain. He rates the pain level 7/10. He describes the pain as moderate to severe, aching, cramping and throbbing. He states the medications are helping. The right shoulder range of motion is restricted with abduction. He has normal extension and extension. He has tenderness to palpation in the biceps groove and glenohumeral joint. Satisfaction of all of these criteria is not currently documented (including non-surgical candidacy, significant functional loss, positive motivation, and addressed negative predictors of success). The criteria noted above not having been met, Functional restoration program was recommended by 2-9-15 QME is not medically necessary.