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| Case Number: | CM15-0105517 | | |
| Date Assigned: | 06/09/2015 | Date of Injury: | 09/17/1999 |
| Decision Date: | 07/10/2015 | UR Denial Date: | 05/11/2015 |
| Priority: | Standard | Application Received: | 06/01/2015 |

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: Preventive Medicine, Occupational 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 (IW) is a 56 year old male who sustained an industrial injury on 09/17/1999. He reported an injury resulting from hanging on to a moving vehicle. The injured worker was diagnosed as having left shoulder rotator cuff injury; history of left shoulder surgery x3, right lateral epicondylitis; myofascial pain syndromes. Treatment to date has included surgeries, steroid injections, physical therapy which gave temporary benefit, and pain medication which he finds helpful. His medications include Norco, OxyContin, Mobic, Gabapentin, and Lipitor. He is treating with a pain management specialist. Currently, the injured worker complains of constant aching, dull pain in the left shoulder and right elbow with radiation to the elbow and shoulder. He rates his pain at a 6/10. The pain is aggravated by arm function, hand function, and activity. The pain also interferes with sleep. On examination of the left shoulder and right elbow, tenderness and swelling were noted, range of motion was decreased, deep tendon reflexes were 2/2 and motor strength was decreased. A request for authorization was made for a Functional Restoration Program for 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 49.

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

Decision rationale: The MTUS Guidelines recommend the use of functional restoration program (FRPs) although research is still ongoing as to how to most appropriately screen for inclusion in these programs. FRPs are geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. Treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. This request is for 6 weeks, which is outside the recommendation of the guidelines, therefore, the request for Functional Restoration Program for 6 weeks is determined to not be medically necessary.