

Case Number:	CM15-0021793		
Date Assigned:	02/11/2015	Date of Injury:	04/17/2013
Decision Date:	03/31/2015	UR Denial Date:	01/13/2015
Priority:	Standard	Application Received:	02/05/2015

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, Hawaii
 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 38 year old male, who sustained a work/ industrial injury on 4/17/13 when he fell through a skylight landing on a metal beam. He has reported symptoms of pain in neck, low back, chest, bilateral shoulder, elbows, and bilateral knee. Prior medical history was noncontributory. The diagnoses have included chronic cervical and lumbar strain, possible bilateral lumbar radiculitis, chest pain (non-cardiac), and bilateral shoulder pain, bilateral knee pain with medial meniscus tear, gait disturbance, and reactive depression. Treatments to date included left shoulder surgery and mandibular open reduction internal fixation (ORIF), Right shoulder and knee surgery was pending along with removal of mandibular hardware. Diagnostics included an Magnetic Resonance Imaging (MRI) of the right knee on 1/21/14 demonstrated medial meniscus oblique tear of the anterior and possibly horizon tear of the body of the medial meniscus. Office visit of 12/5/14 reported IW complaining of bilateral shoulder pain, chest wall pain, thoracic pain, bilateral knee pain, lower back pain, and heel pain. Physical exam was positive for anxiety, negative for joint swelling and stiffness, tenderness of the right acromioclavicular and glenohumeral joints, right shoulder abduction, flexion to 160 degrees associated with pain, strength 4/5 of the bilateral upper extremities, tenderness of the lumbar paraspinal muscles, increased pain with extension of flexion of the low back, right knee joint line tenderness, minimal swelling in the knee, full extension and flexion to 105 degrees with pain and strength 4/5 of the right lower extremity. Medications included Norco, Mirtazapine, Rozerem, Nametone, and Gabapentin. The request is for 160 hours of a functional restoration program (FRP). On 1/13/15, Utilization Review non-certified a 180 Hours of functional restoration

program, noting the California Medical treatment Utilization Schedule (MTUS), Chronic Pain Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

180 Hours of functional restoration program: 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 Program Page(s): 49.

Decision rationale: The patient presents with bilateral shoulder, chest wall, thoracic, knee, lower back and heel pain. The current request is for 180 Hours of Functional Restoration Program. The treating physician states, "He describes this pain as deep aching, burning, and radiating. Bunionectomy shoulders and upper extremities; also lower back pain, increasing with activity radiating to the left posterior leg to his feel. Increased pain into the lower back causing more difficulty sleeping." (B.111) There is no further discussion of the current request in the report dated 12/19/14. The MTUS guidelines recommend functional restoration programs. However there are 6 criteria that must be met for the recommendation for FRP. Those six criteria are: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. In this case, there is no adequate and thorough evaluation provided indicating the need for a functional restoration program. The treating physician has not documented that the patient has a significant loss of ability to function independently and there is no documentation that the patient exhibits motivation to change. The criteria required for authorization of a functional restoration program are not documented for this patient. The current request is not medically necessary and the recommendation is for denial.