

Case Number:	CM15-0053964		
Date Assigned:	03/27/2015	Date of Injury:	11/04/2014
Decision Date:	05/01/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/21/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 an industrial injury on 11/04/2014. He reported shoulder pain. The injured worker was diagnosed as having contusion of shoulder/upper arm. Treatment to date has included x-rays, MRI of the left shoulder, arm sling, Toradol injections, 14 sessions of physical therapy and medications. According to a progress report dated 01/19/2015, the injured worker complains of constant severe left shoulder pain, constant moderate left elbow pain and intermittent moderate cervical pain. Diagnoses included cervical disc herniation without myelopathy, partial tear of rotator cuff tendon of the left shoulder and left radiohumeral sprain/strain. Treatment plan included surgical orthopedic consultation to evaluate treatment options for a torn glenohumeral labrum and an impact injury to the lesser tuberosity. According to a progress report dated 02/19/2015, the injured worker was seen by an orthopedic surgeon on 02/17/2015 and was advised to continue with therapy. The provider noted that following 14 physical medicine sessions that the injured worker had reached a plateau. Treatment plan included acupuncture, Functional Capacity Evaluation, work hardening screening and psychosocial factors screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Work conditioning hardening screening: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7: Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Hardening Page(s): 125-126.

Decision rationale: The California chronic pain medical treatment guidelines section on work hardening states: Recommended as an option, depending on the availability of quality programs. Criteria for admission to a Work Hardening Program: (1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA). (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning. (3) Not a candidate where surgery or other treatments would clearly be warranted to improve function. (4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. (5) A defined return to work goal agreed to by the employer & employee: (a) A documented specific job to return to with job demands that exceed abilities, OR (b) Documented on-the-job training (6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with the program). Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program. (7) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit. (8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less. (9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities. (10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. Per the guidelines above this is suited for patient's where surgery is not an option of treatment. However, surgery is an option. Therefore, criteria have not been met and the request is not medically necessary

Qualified functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7: Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Functional Capacity Evaluation.

Decision rationale: The California MTUS and the ACOEM do not specifically address functional capacity evaluations. Per the ODG, functional capacity evaluations (FCE) are recommended prior to admission to work hardening programs, with preference for assessments tailored to a specific job. Not recommended as a routine use as part of occupational rehab or screening or generic assessments in which the question is whether someone can do any type of job. Consider FCE1. Case management is hampered by complex issues such as: a. Prior unsuccessful RTW attempts b. Conflicting medical reporting on precaution and/or fitness for modified jobs c. Injuries that require detailed exploration of the worker's abilities 2. Timing is appropriate a. Close or at MMI/all key medical reports secured b. Additional/secondary conditions clarified. There is no indication in the provided documentation of prior failed return to work attempts or conflicting medical reports or injuries that require detailed exploration of the worker's abilities. Therefore, criteria have not been met as set forth by the ODG and the request is not certified.

Psychosocial factors screening: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-101.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychology Treatments Page(s): 101-102.

Decision rationale: The California chronic pain medical treatment guidelines section on psychological treatment states: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005) Psychological treatment in particular cognitive behavioral therapy has been found to be particularly effective in the treatment of chronic pain. The provided documentation does not indicate the reasons behind psychology evaluation besides possible upcoming surgery, which has yet to be approved. Therefore, the request is not medically necessary.