

<b>Case Number:</b>	CM15-0055453		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	02/24/2006
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	03/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 48-year-old female who reported injury on 02/24/2006. The mechanism of injury was not provided. The injured worker underwent an anterior cervical discectomy with interbody fusion on 02/20/2001, a left shoulder surgery on 03/03/2008 and on 11/02/2012. The injured worker underwent postoperative physical therapy, 6 sessions of psychiatric therapy, and visits with pain management specialists. The documentation of 03/05/2015 revealed the injured worker had decreased cervical and left shoulder range of motion. There was positive rotator cuff impingement test of the left shoulder. There was decreased strength and range of motion in the left shoulder. The injured worker was noted to be emotional. The diagnoses included left shoulder rotator cuff injury, tendinitis, left shoulder lateral epicondylitis, left labrum tear, cervical sprain and strain, cervical disc injury and cervical herniation. The treatment plan included Neurontin 300 mg 1 tablet twice a day, Lidoderm, and Tylenol No. 3. The documentation indicated the injured worker should have a Functional Capacity Evaluation to assess residual capacity and to have a Functional Restoration Program evaluation for worsening pain and discomfort and the recommendation was for a spine physician for a second opinion. There was a Request for Authorization submitted for review dated 03/05/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, FCE.

**Decision rationale:** The American College of Occupational and Environmental Medicine guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation, however, it does not address the criteria. As such, secondary guidelines were sought. The Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work. There was a lack of documentation indicating the injured worker had a prior failure of a return to work. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for Functional Capacity Evaluation is not medically necessary.

**Functional Restoration Program: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Program, Functional Restoration Program Page(s): 30-32.

**Decision rationale:** The California Medical Treatment & Utilization Schedule Guidelines indicate that a Functional Restoration program is recommended for patients with conditions that put them at risk of delayed recovery. The criteria for entry into a functional restoration program includes an adequate and thorough evaluation that has been made including baseline functional testing so follow-up with the same test can note functional improvement, documentation of previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, documentation of the patient's significant loss of the ability to function independently resulting from the chronic pain, documentation that the injured worker is not a candidate for surgery or other treatments would clearly be warranted, documentation of the injured worker having motivation to change and that they are willing to forego secondary gains including disability payments to effect this change, and negative predictors of success has been addressed. Additionally it indicates the treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The clinical documentation submitted for review indicated the Functional Restoration Program was for the injured worker's worsening pain and discomfort. The request per the physician documentation was for a functional restoration program evaluation. The injured worker was noted to be injured in 2006. The prior therapies and treatments were not provided. The request as submitted failed to indicate the frequency and quantity for the Functional Restoration Program as well as the total hours being requested.

Additionally, the request per the physician documentation was for the program, not for the evaluation. Given the above, the request for Functional Restoration Program is not medically necessary.

**Consultation/evaluation with brain and spine specialist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation submitted for review failed to provide rationale for the requested consultations. There was a lack of documentation indicating the specific concept that was being requested. The documentation indicated the injured worker had previously been treated with psych therapy. However, there was a lack of documentation indicating a necessity for a repeat evaluation. There was a lack of documentation indicating a necessity for a spine specialist. The rationale was not provided. Given the above, the request for consultation/evaluation with brain and spine specialist is not medically necessary.

**Pharmacologic management with brain and spine specialist times six:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Office Visits.

**Decision rationale:** The Official Disability Guidelines indicate that office visits are recommended due to a review of the injured worker's concerns, signs and symptoms, clinical stability and reasonable physician judgment. The medications that would need management were not provided. The request as submitted failed to provide a rationale for the requested evaluation times 6. Without clarification, the request for pharmacologic management with brain and spine specialist times six is not medically necessary.