

<b>Case Number:</b>	CM15-0089327		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	08/29/2014
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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: 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 57 year old male, who sustained an industrial injury on 8/29/2014. He reported slipping and falling onto the left side and developed pain in the left shoulder, low back, with numbness and tingling going down the left leg. Diagnoses include left lumbar radiculopathy, spondylosis, chronic pain syndrome and chronic shoulder pain, status post left rotator cuff repair. Treatments to date include activity modification, medication therapy, physical therapy, and epidural steroid injection reported to have provided no relief in pain. Currently, he complained of slow steady progress with discomfort in the anterior shoulder and with overhead activity. He is status post left rotator cuff repair on 12/23/14. On 4/22/15, the physical examination documented decreased range of motion and decreased strength with decreased sensation in the left leg. The plan of care included a functional restoration program for two weeks and a work-conditioning program up to two hours.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Restoration program x 50 hours = 2 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
 Page(s): 31-32.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 49.

**Decision rationale:** The patient was injured on 08/29/14 and presents with pain in his left shoulder and low back with numbness/tingling going down the left leg. The request is for FUNCTIONAL RESTORATION PROGRAM X 50 HOURS = 2 WEEKS. There is no RFA provided and the patient's work status is not provided. MTUS guidelines page 49 recommends functional restoration programs and indicate it may be considered medically necessary when all criteria are met including (1) adequate and thorough evaluation has been made (2) Previous methods of treating chronic pain have been unsuccessful (3) significant loss of ability to function independently resulting from the chronic pain; (4) not a candidate for surgery or other treatments would clearly be (5) The patient exhibits motivation to change (6) Negative predictors of success above have been addressed. MTUS page 49 also states that up to 80 hours or 2-week course is recommended first before allowing up to 160 hours when significant improvement has been demonstrated. The patient is diagnosed with left lumbar radiculopathy, spondylosis, chronic pain syndrome and chronic shoulder pain, and status post left rotator cuff repair. He has an antalgic gait, decreased sensation to light touch in the left medial calf, and a positive slump test on the left side. Treatments to date include activity modification, medication therapy, physical therapy, and an epidural steroid injection. The 04/22/15 report states that the treater would like a FRP "in order to comprehensively decrease his pain, his activities of daily living have decreased by 50%. His lumbar range of motion is decreased. He has failed injection therapy, multiple opioid medication and recommend treatments including Norco, NSAID therapy such as ibuprofen, Naproxen, and neuropathic pain medications such as gabapentin. The patient meets MTUS Guidelines for two week functional restoration program for a total of 50 hours of contact time, so that the patient is able to improve his functionality, decrease his opioid medication and return to work." There is no documentation of any prior FRP the patient may have had. In this case, there is no thorough evaluation regarding the patient's candidacy for FRP. The negative predictors are not addressed as required by MTUS. The patient's secondary gain issues, motivation to change and improve, and any potential for surgical needs are not addressed. The request Functional Restoration Program IS NOT medically necessary.

**Work conditioning program up to 2 hrs: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 125. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines work hardening programs Page(s): 125-126.

**Decision rationale:** The patient was injured on 08/29/14 and presents with pain in his left shoulder and low back with numbness/tingling going down the left leg. The request is for WORK CONDITIONING PROGRAM UP TO 2 HOURS. There is no RFA provided and the patient's work status is not provided. The report with the request is not provided. The MTUS Guidelines pages 125-126 recommends work hardening programs as an option and requires

specific criteria to be met for admission, including work-related musculoskeletal condition with functional limitations, trial of PT with improvement followed by plateau, nonsurgical candidate, define return to work goal agreed by employer and employee, etc. A defined returned to work goal is described as; (a) A documented specific job to return to with job demands that exceeds abilities, or (b) Documented on the job training. Furthermore, Approval of this program should require a screening process that includes file review, interview, and testing to determine likelihood of success in the program. The reason for the request is not provided. The patient is diagnosed with left lumbar radiculopathy, spondylosis, chronic pain syndrome and chronic shoulder pain, and status post left rotator cuff repair. He has an antalgic gait, decreased sensation to light touch in the left medial calf, and a positive slump test on the left side. Treatments to date include activity modification, medication therapy, physical therapy, and an epidural steroid injection. In this case, the treater has not discussed the results of the screening process that is required prior to consideration of work hardening or whether the patient has gone through the screening process or not. There is no documentation of a specific job to return to either, and whether or not the patient is able to tolerate the program as required by MTUS. The request does not meet the criteria for work conditioning. Therefore, the requested Work Conditioning Program IS NOT medically necessary.