

Case Number:	CM14-0160165		
Date Assigned:	10/03/2014	Date of Injury:	09/30/1998
Decision Date:	10/31/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	09/29/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 62-year-old male who reported an injury on 09/30/1998 due to an unknown mechanism. Diagnoses were not reported. Physical examination on 08/21/2014 revealed that the injured worker was discussing a procedure of artificial disc replacement at the C6-7 level. The injured worker reported he continued to have pain in the right side of his neck into the shoulder girdle. He stated that the arm and neck motion increased the pain. The injured worker denied any new weakness, numbness, or tingling. The injured worker described a burning sensation in the upper arm and shoulder area on the right side when the pain was increased. Physical examination revealed strength was 5/5 from C5 to T1 bilaterally. Deep tendon reflexes were normoreflexic. The rationale and request for authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional restoration program evaluation, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs) Page(s): 3.

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

Decision rationale: The decision for Functional restoration program evaluation, QTY: 1 is not medically necessary. 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 patient is not a candidate for surgery, or other treatments would clearly be warranted, documentation of the patient having motivation to change and that they are willing to forgo secondary gains including disability payments to effect this change, and negative predictors of success have 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 rationale for requesting functional restoration program evaluation, quantity 1 was not reported. Previous methods for treating the injured workers' pain were not reported. The clinical information submitted for review does not provide evidence to justify this request. Therefore, this request is not medically necessary.