MAXIMUS Federal Services

Case Number:	CM14-0211204		
Date Assigned:	12/24/2014	Date of Injury:	09/25/2006
Decision Date:	02/19/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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 & Rehabn

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 patient is a 48 year old female with an injury date of 09/25/06. Based on the 07/02/14 progress report, the patient complains of shoulder and neck pain with radiation to her upper extremities, hands, fingers, lower back, and lower extremities. She rates her pain as a 4-5/10 with medication and an 8-9/10 without medication. The 08/27/14 report states that the patient's pain affects her ability to perform her activities of daily living including cooking, cleaning, and toileting. She has diffuse tenderness to palpation over the anterior chest wall, cervical, thoracic, and lumbar spine. She ambulates slowly with an antalgic gait, has a decreased sensation of the dermatomal pattern on the bilateral lower extremities, and has bilateral wrist braces. The 10/24/14 report does not provide any new additional positive exam findings. The patient's diagnoses include the following: 1.Chronic pain syndrome. 2.Right shoulder impingement. 3.Cervical radiculopathy. 4.Insomnia. 5.Lumbar radiculopathy. 6.Bilateral carpel tunnel syndrome. 7.Depression- Cymbalta, some increased nor-epinephrine effect. The utilization review determination being challenged is dated 11/20/14. There are three treatment reports provided from 07/02/14, 08/27/14, and 10/24/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program x 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-32.

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

Decision rationale: The patient presents with shoulder and neck pain with radiation to her upper extremities, hands, fingers, lower back, and lower extremities. The request is for a Functional restoration program x 6 weeks. The utilization review denial letter indicates that the patient has previously participated in the functional restoration program (date of FRP participation 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's pain affects her ability to perform her activities of daily living including cooking, cleaning, and toileting. She ambulates slowly with an antalgic gait, has a decreased sensation of the dermatomal pattern on the bilateral lower extremities, has bilateral wrist braces, and has diffuse tenderness to palpation over the anterior chest wall, cervical, thoracic, and lumbar spine. In this case, the treater asks for functional restoration program, but does not indicate why it is needed at this point and what can be accomplished with additional FRP. There is no documentation how the patient has benefited from the previous FRP nor does the treater discuss what more is to be accomplished with additional FRP. Furthermore, the treater is requesting for 6 weeks of the FRP which exceeds the 160 hours MTUS Guidelines allows after the 2 week trial. The requested functional restoration program is not medically necessary.