

<b>Case Number:</b>	CM15-0011714		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	06/08/2014
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: 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 61- year old male, who sustained an industrial injury on January 8, 2014. He has reported injury that was due to cumulative trauma. The diagnoses have included cervical and lumbar spine sprain/strain, cervical spine myospasm, lumbar spine radiculitis, right shoulder sprain/strain, right shoulder impingement, tension headaches, lumbar spine disc desiccation, multi-level disc protrusions of the lumbar spine and right shoulder calcific tendinitis. Treatment to date has included physical therapy, acupuncture therapy, pain medication, chiropractic therapy, rest, activity restriction, cold/heat therapy and routine monitoring. Currently, the IW complains of intermittent right shoulder pain that is moderate to severe. There is low back pain, which is mild to moderate. The back pain radiates to the groin and down the right leg. Pain was described as sharp, pulsing, numbing and deep. Pain is reported to increase with certain movements such as pushing and pulling. Pain was relieved with rest. Pain was also reported to be adequately controlled with the current pain medication regime. Physical exam was remarkable for tenderness to palpation with spasms of the upper trapezius muscles and the lumbar spine. Range of motion of the cervical spine was decreased. The left shoulder was documented as having decreased range of motion and decrease strength. On January 7, 2015, the Utilization Review decision non-certified a request for supervised functional restoration program two times per week for six weeks, noting that in order for this to be approved a functional restoration evaluation should be completed at the end of physical therapy and it indicated the worker had plateaued with improvement. The MTUS Chronic Pain Medical Treatment Guidelines was

cited. On January 15, 2015, the injured worker submitted an application for IMR for review of supervised functional restoration program two times per week for six weeks.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Supervised functional restoration program 2 x a week x 6 weeks for cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Program) Page(s): 31.

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

**Decision rationale:** According to the 12/22/2014 report, this patient presents with intermittent right shoulder and constant low back pain. The current request is for Supervised Functional Restoration Program 2xWk x 6Wks Cervical Spine. The patient's work status is "Total Temporary Disability for 8 weeks." Regarding functional restoration programs, MTUS guidelines pg. 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. Review of the provided reports from 09/25/2014 to 12/22/2014, the treating physician does not document that the patient has meet the 6 criteria of MTUS guidelines. Without accomplishing all 6 criteria of the MTUS guidelines, the request cannot be recommended for authorization. Therefore, the request IS NOT medically necessary.