

Case Number:	CM15-0173210		
Date Assigned:	09/15/2015	Date of Injury:	10/27/2014
Decision Date:	10/23/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/02/2015

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, Hawaii

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 female who sustained a cumulative industrial injury on 10-27-14 to her head, neck, left shoulder, low back, hips, and knees. She has been on disability since 3-12-15. Diagnoses included headache; cervical, thoracic, lumbar sprain-strain rule out discogenic pain; left shoulder sprain-strain, rule out discogenic pain; bilateral hip sprain-strain; bilateral knee sprain-strain, rule out impingement; anxiety; depression; insomnia; history of gastritis; osteoporosis. She currently (4-28-15) complains of intermittent neck pain radiating to the left upper extremity with a pain level of 8 out of 10; intermittent low back pain radiating down bilateral legs, knees and ankles with a pain level of 8 out of 10; headaches; left shoulder pain; with a pain level of 5 out of 10; right (7-8 out of 10) and left knee pain and weakness; bilateral hip pain (7-8 out of 10); depression; stress. On physical exam there was tenderness of the cervical spine with full but painful range of motion; tenderness on palpation of the lumbar with decreased range of motion and tenderness of the thoracic spine; positive straight leg raise bilaterally; tenderness on palpation of the left shoulder, decreased range of motion, positive apprehension test on the left; hip was tender to palpation with full but painful range of motion bilaterally; bilateral knees were tender to palpation with painful range of motion. Diagnostics include right knee x-ray (4-7-15) showing osteoarthritis; x-ray of the left shoulder (4-7-15) showing osteopenia secondary to post-menopausal osteoporosis; MR of the lumbar spine (2-10-15) showing mild degenerative disc and facet joint disease, disc bulging. Treatments to date include medications: omeprazole, cyclobenzaprine, gabapentin; acupuncture. In the progress note dated 4-7-15 the treating provider's plan of care included a request for functional improvement measures. On 8-18-15 utilization review evaluated and non-certified the request for functional improvement measures.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Improvement Measures: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures.

Decision rationale: The medical records indicate the patient has complaints of neck pain traveling into the left upper extremity, low back pain traveling into the lower extremities bilaterally, left knee pain, left shoulder pain, and bilateral hip pain. The current request for consideration is Functional Improvement Measures. The CA MTUS does recommend Functional Improvement Measures. CA MTUS states the importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include the following categories: Work Functions and/or Activities of Daily Living, Self Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc): Objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc (Oswestry, DASH, VAS, etc.). Physical impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees. Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider's assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. (California, 2007) For chronic pain, also consider return to normal quality of life, e.g., go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life. In this case, routine self-assessment questionnaires pertaining to ADLs and pain scales are routine functional improvement measures, which are routinely provided during a re-evaluation of a patient's status. Furthermore, range of motion studies and repetitive bending/squatting, walking, driving, standing, and sitting tolerances are routine functional measurements performed during an examination of a patient during a routine follow-up. The treating physician in this case offers no explanation as to the reasoning for requesting functional improvement measures. As such, the available medical records do not establish the need for additional functional improvement measures beyond what is routinely performed in a follow-up evaluation. The current request is not medically necessary.