

Case Number:	CM15-0068917		
Date Assigned:	04/16/2015	Date of Injury:	07/11/2009
Decision Date:	05/15/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/10/2015

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, Pain Management

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 59-year-old female, with a reported date of injury of 07/11/2009. The diagnoses include left shoulder rotator cuff injury, left shoulder sprain/strain, left shoulder adhesive capsulitis, and left frozen shoulder. Treatments to date have included home exercises, topical pain medications, and oral medications. The medical report dated 03/19/2015 indicates that the injured worker had ongoing pain in her left shoulder. She reported increased pain and discomfort involving her left shoulder. The objective findings include tenderness to palpation of the left-sided acromioclavicular joint, myofascial tightness in the left side of her cervical spine, left positive impingement signs, and painful range of motion of the left side. The treating physician requested a functional restoration program evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional restoration program evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 30-34 and 49 of 127.

Decision rationale: Regarding the request for a functional restoration program, California MTUS supports chronic pain programs/functional restoration programs when: Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; The patient has a significant loss of ability to function independently resulting from the chronic pain; The patient is not a candidate where surgery or other treatments would clearly be warranted; The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success above have been addressed. Within the medical information available for review, there is no documentation that an adequate and thorough evaluation has been made including baseline functional testing, no statement indicating that other methods for treating the patient's pain have been unsuccessful, no statement indicating that the patient has lost the ability to function independently, and no statement indicating that there are no other treatment options available. Additionally, there is no discussion regarding motivation to change and negative predictors of success. In the absence of clarity regarding the above issues, the currently requested functional restoration program is not medically necessary.