

Case Number:	CM13-0018037		
Date Assigned:	09/30/2013	Date of Injury:	11/04/1994
Decision Date:	02/13/2014	UR Denial Date:	08/13/2013
Priority:	Standard	Application Received:	08/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in New York and Texas. 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 physician 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.

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 67-year-old female who reported an injury on 11/04/1994. The mechanism of injury was noted to be lifting. The patient has been diagnosed with rotator cuff tendinopathy/impingement syndrome and AC joint arthrosis. Her symptoms are noted as right shoulder pain. Her physical examination findings included tenderness over the greater tuberosity in the AC joint, an equivocal O'Brien's test, positive impingement sign, positive Hawkins sign, positive supraspinatus weakness test, positive extension rotation test, positive crepitus with range of motion, limited range of motion, limited motor strength, and pain with range of motion activities. It was noted that the patient has previously failed conservative care, medications, limited activities, home exercises, and local steroid injection into the subacromial space. A recommendation was made for right shoulder arthroscopy with subacromial decompression, possible rotator cuff repair, and distal clavicle resection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management program for six (6) months with [REDACTED] for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs Page(s): 30-31.

Decision rationale: The California MTUS Guidelines state that the criteria for use of chronic pain programs include that an adequate and thorough evaluation has been made, including baseline functioning testing so follow-up with the same test can note functional improvement; 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 be clearly warranted; the patient exhibits motivation to change; and negative predictors of success have been addressed. The patient is noted to have significant pain related to her right shoulder and recent documentation states she was taking a number of pain medications; however, there was not an updated list of her current medications for review. Additionally, the patient does not meet the criteria for a chronic pain program, as there was not an adequate and thorough evaluation submitted for review, which included baseline functional testing, the patient has been recommended for surgery, there is no documentation that the patient exhibits motivation to change, and negative predictors of success were not addressed in the medical records. Additionally, the Guidelines state that treatment in a chronic pain program is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Therefore, the request for 6 months of a chronic pain program is excessive and not supported by the Guidelines. For these reasons, the request for pain management program for six (6) months with [REDACTED] for the lumbar spine is non certified.