

Case Number:	CM14-0040302		
Date Assigned:	06/27/2014	Date of Injury:	09/23/2013
Decision Date:	08/18/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/07/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 reported an injury on 09/23/2013. The mechanism of injury was not provided. On 05/21/2014, the injured worker presented with dizziness, back pain, feet and ankle pain, ringing in the ears, right wrist pain, and severe forgetfulness. Upon examination, there was tenderness over the paraspinal musculature and decreased range of motion secondary to pain. There was a right foot/ankle pain and right wrist strain with a chest contusion. Prior treatment included physical therapy, acupuncture, and medications. The provider recommended a pain management referral, and the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management referral for evaluation and treatment for diagnosis of left shoulder pain, rotator cuff sprain: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): page(s) 1.

Decision rationale: The request for pain management referral for evaluation and treatment for diagnosis of left shoulder pain, rotator cuff sprain is not medically necessary. The California MTUS Guidelines state that if their complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation provides no evidence that the current treatment requested for the left shoulder and rotator cuff failed to result in improvement in the injured worker's pain complaints or that he requires complex pain management for control of his complaints. Based on this submitted documentation reviewed and the medical guidelines, a pain management consultation would not be indicated. As such, the request is not medically necessary.