MAXIMUS Federal Services

Case Number:	CM14-0044343		
Date Assigned:	04/14/2014	Date of Injury:	05/29/2005
Decision Date:	07/14/2014	UR Denial Date:	03/07/2014
Priority:	Standard	Application Received:	03/18/2014

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 Internal Medicine and is licensed to practice in New York. 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 patient is a 48 year old male who was injured on 05/29/2005 when he fell while working in the kitchen. His diagnoses are left shoulder rotator cuff injury, frozen left shoulder, left shoulder sprain/strain, and s/p left shoulder surgery. Treatment history has included medical therapy with narcotics and six sessions of physical therapy. The patient underwent subacromial decompression, distal clavicle resection and glenohumeral joint synovectomy of the left shoulder on 02/23/2006. He also underwent subacromial decompression; resection of heterotopic ossification; acromioclavicular joint reconstruction; Weaver-Dunn procedure on 02/01/2007. On 01/22/2009, he underwent resection of heterotopic ossification and subacromial bursectomy. An MRI of the lumbar spine dated 01/08/2013 revealed disc bulge at L4-5 posterolaterally on the right producing L4 foraminal stenosis. An MRI of the right shoulder dated 01/08/2013 revealed impingement syndrome without definite tear. Increased signal and the horizontal portion of the biceps tendon may represent tendinitis. An MRI of the left shoulder dated 09/26/2012 revealed mild hyperintense signal and swelling of the insertional fibers of supraspinatus and infraspinatus tendons suggested of tendinosis. An orthopedic consultation by [redacted] stated that the patient's current therapy for upper extremity condition is secondary to specific industrially related trauma. A physical therapy progress note dated 06/26/2007 documented the patient to have complaints of acute pain in left shoulder 10/10, crackling in left shoulder and left arm to the hand. Still gets numb at times. He reports being unable to perform any of his job duties. A progress note dated 02/27/2014 documented the patient has noticed an increase in pain and discomfort involving the left shoulder. Objective findings on exam reveal decreased range of motion of the left shoulder. DTRs are 2/2 biceps, triceps and radialis. There is decreased sensation to touch of the left shoulder and upper extremity. There is positive impingement test of the left shoulder and left shoulder muscle atrophy. A progress note dated 03/27/2014

documented that the patient is still symptomatic with pain and discomfort involving the left shoulder. Objective findings on exam revealed a decrease in range of motion of the left shoulder. DTRs are 2/2 biceps, triceps and radialis. There is decreased sensation to touch of the left shoulder and upper extremity. There is positive impingement test of the left shoulder and left shoulder muscle atrophy. The treating provider has requested an initial evaluation for functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

INITIAL EVALUATION FOR FUNCTIONAL RESTORATION PROGRAM: 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 Functional Restoration programs, Chronic pain programs (functional restoration programs) Page(s): 49, 30-33.

Decision rationale: As per the MTUS Chronic Pain Guidelines, "the following variables have been found to be negative predictors of efficacy of treatment with the functional restoration programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pretreatment levels of pain." In this case, this patient continues to have increased left shoulder pain and discomfort with significant emotional issues. A recent psychological evaluation testing and interview done on 02/12/2014 indicates he continues to have severe anxiety and depression secondary to chronic pain. Thus, the above negative predictors of efficacy of treatment have not been completely addressed and resolved. Medical necessity for the requested item has not been established. The requested item is not medically necessary.