

<b>Case Number:</b>	CM14-0121178		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	08/28/2002
<b>Decision Date:</b>	06/29/2015	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2014

### 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. 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: Arizona, California

Certification(s)/Specialty: Family Practice

### 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 48 year old male who sustained an industrial injury on 8/28/02. The injured worker was diagnosed as having neck pain, myofascial pain, shoulder pain, cervical disc with radiculitis and carpal tunnel syndrome. Currently, the injured worker was with complaints of pain in the neck, bilateral arms and back. Previous treatments included medication management, status post bilateral carpal tunnel release, injections; status post left shoulder arthroscopic subacromial decompression and glenohumeral synovectomy and activity modification. Previous diagnostic studies included a magnetic resonance imaging, electromyography and nerve conduction velocity study. Physical examination was notable for left shoulder with decreased range of motion and tenderness to palpation. The plan of care was for multidisciplinary evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Multidisciplinary Evaluation # 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines multidisciplinary program Page(s): 31-33.

**Decision rationale:** Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. In this case, the claimant was able to ambulate and there was no baseline functional exam assessment performed to determine improvement from baseline. There were no postural abnormalities. There was no mention for surgical deferral. As a result, the request for a multidisciplinary program evaluation is not medically necessary.