

Case Number:	CM14-0134508		
Date Assigned:	08/29/2014	Date of Injury:	01/31/2006
Decision Date:	01/26/2015	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/20/2014

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 Family Practice and is licensed to practice in California. 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:

This 60 year old male claimant sustained a work injury on 1/31/06 involving the left shoulder, neck and back. He was diagnosed with chronic pain in the involved areas and additionally had bipolar disorder, asthma, insomnia and bronchitis. He had a SLAP tear of the left shoulder for which he underwent surgery in 2006. The claimant had previously undergone physical therapy. He had received a spinal cord stimulator in 2012 which dramatically reduced symptoms. A progress note on 7/11/14 indicated the claimant had tenderness in the left upper extremity and decreased range of motion of the left shoulder. He was not a candidate for additional surgery. He has loss of sleep secondary to pain. His impairment does not allow him to fully take care of himself and his financial situation is dire. The physician requested an initial evaluation for multidisciplinary pain management and functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

One Day Interdisciplinary Pain Management Evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRP's).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Multidisciplinary Pain Management Programs Page(s): 31-33.

Decision rationale: According to the guidelines, 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. Based on the claimant's history, he has tried and failed conservative and surgical options. He is motivated to improve himself and has loss significant ability to function. The request above is appropriate and medically necessary.