

Case Number:	CM14-0211290		
Date Assigned:	12/24/2014	Date of Injury:	09/07/2007
Decision Date:	02/27/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/17/2014

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 is a 53 year old patient with date of injury of 09/07/2007. Medical records indicate the patient is undergoing treatment for Chronic Myofascial Pain Disorder, RSI upper extremities, Left painful frozen shoulder. Subjective complaints include wide spread areas of pain worse in the left shoulder. Objective findings include radiographs on 03/19/2014: Mild diffuse hypertrophic bony degenerative changes of the right shoulder; Mild diffuse bony degenerative changes of the left shoulder. Treatment has consisted of physical therapy, occupational hand therapy, massage treatment, acupuncture, chiropractic care, left sling and bilateral wrist support, Vicodin, Tylenol with Codeine, Ibuprofen and Prozac. The utilization review determination was rendered on 12/04/2014 recommending non-certification of Pain Management and MRI of the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised

2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain program Page(s): 30-34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Chronic Pain Programs.

Decision rationale: MTUS states, "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." ODG states concerning chronic pain programs "(e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function." While the treating physician does document the use of opioids and anti-depressants, the treating physician has not provided detailed documentation of chronic pain treatment trials and failures to meet all six MTUS criteria for a chronic pain management program. As such, the request for pain management is not medically necessary.

MRI of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 178, table 8-7, and pages 208 - 209, table 9-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI).

Decision rationale: ACOEM states 'Primary criteria for ordering imaging studies are:- Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems)- Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or

the presence of edema, cyanosis or Raynaud's phenomenon)- Failure to progress in a strengthening program intended to avoid surgery.- Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment)" ODG states "Indications for imaging Magnetic resonance imaging (MRI):- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs- Subacute shoulder pain, suspect instability/labral tear- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology."The treating physician has not documented any red flag symptoms, acute shoulder trauma, instability, weakness or suspected tears. As such, the request for MRI of the left shoulder is not medically necessary.