

Case Number:	CM13-0063504		
Date Assigned:	12/30/2013	Date of Injury:	01/19/2013
Decision Date:	05/12/2014	UR Denial Date:	11/15/2013
Priority:	Standard	Application Received:	12/09/2013

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 Orthopedic Surgery 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:

The injured worker reported an injury on 01/19/2013. The mechanism of injury was not submitted. The injured worker was diagnosed with chronic shoulder pain. An office visit dated 08/12/2013 stated the injured worker was awaiting physical therapy for the shoulder. The injured worker was not using any medication at the time. The injured worker complained the pain was worse with cold temperature. The injured worker had tenderness to palpation at the left suprascapular region, there was pain with abduction. The injured worker was recommended physical therapy and Motrin 800 mg. The injured worker was given a Toradol injection. The orthopedic evaluation dated 10/31/2013 state the injured worker remained symptomatic. The injured worker had neck pain that was rated at 5/10 and bilateral shoulder pain rated at 4.5/10 as well as occasional headaches. The injured worker also reported depression, anxiety, and difficulty sleeping. The injured worker had decreased active range of motion with the left shoulder and painful arc against resisted abduction. The injured worker had myofascial tenderness to palpation bilaterally of the trapezius and anterolateral shoulder. There was supraspinatus tendon tenderness to palpation and a positive impingement test. The injured worker had been treated with activity modification, medications, physical therapy, and subacromial cortisone injections. The physician's progress report dated 12/12/2013 stated the injured worker remained symptomatic since the last office visit. The injured worker rated her right shoulder pain at 4/10 and left shoulder pain at 6/10. The injured worker also complained of occasional headaches rated at 6/10. The injured worker reported symptoms of depression, anxiety, and difficulty sleeping. The injured worker stated that neither the psychologist nor neurologist called her for an appointment. The physician's progress report stated the injured worker had an MRI of the left shoulder on 08/19/2013 that showed no rotator cuff tear. The injured worker had electrodiagnostic testing that revealed evidence of entrapment neuropathy

was seen in the lower extremities; electromyographic indicators of acute lumbar radiculopathy were not seen. The injured worker was recommended a left shoulder arthroscopy, psychiatric evaluation due to severe anxiety and depression, postoperative IF/cold unit, neuro consultation for headaches, postoperative Vicodin and postoperative physical therapy 3 times a week for 2 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, diagnostic arthroscopy section.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: CA MTUS/ACOEM states clear clinical imaging evidence is needed before surgical considerations are recommended. There must also be a failure of conservative treatment to include physical therapy. The injured worker complained of chronic left shoulder pain; however, no MRI was submitted for review to show evidence of shoulder insult. Given the lack of documentation to support guideline criteria, the request for a left shoulder arthroscopy is non-certified.

POST OP IF/COLD UNIT FOR 3 WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder regarding, Continuous Flow Cryotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), continuous-flow cryotherapy.

Decision rationale: As the corresponding request for a left shoulder arthroscopy is not medically supported, post-operative interferential treatment and cold unit is not needed. Given the lack of documentation to support guideline criteria, the request is non-certified.

PSYCHIATRIC EVALUATION: Overturned

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 Psychological Evaluations Page(s): 101.

Decision rationale: CA MTUS states psychological evaluations are recommended for patients with chronic pain problems. The guidelines also state diagnostic evaluations should distinguish conditions that are pre-existing and aggravated by current injury or work related. The request was previously denied due to a lack of documentation of the injured worker reporting signs and symptoms of depression, anxiety, and poor sleep. The orthopedic re-evaluation dated 10/31/2013 stated the injured worker complained of depression, anxiety, and difficulty sleeping. As such, the request for a psychiatric evaluation is certified.

NEURO CONSULT FOR HEADACHES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Independent Medical Examinations and Consultations regarding Referrals, Chapter 7.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: CA MTUS/ACOEM states referrals may be appropriate when treating a particular case of delayed recovery where the physician has difficulty obtaining information or agreement to treatment plan. The goal of such an evaluation is functional recovery and return to work. The injured worker was recommended a neuro consult for headache; however, the clinical documentation submitted for review does not show the injured worker's treatment for the headaches. The documentation also did not show evidence of a description of the headaches, frequency of the headaches, or if the condition is interfering with activities of daily living. Given the lack of documentation to support guideline criteria, the request for neuro consult for headaches is non-certified.

**POST OP ANALGESIC MEDICATION VICODIN ES 1 TABLET EVERY 4-6 HRS:
Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use Page(s): 77.

Decision rationale: As the corresponding request for left shoulder arthroscopy is not medically supported, the request for postoperative analgesic medication Vicodin ES 1 tablet every 4 to 6 hours is not needed. Given the lack of documentation to support guideline criteria, the request is non-certified.

**POST OP PHYSICAL THERAPY THREE TIMES A WEEK FOR TWO MONTHS:
Upheld**

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

Decision rationale: As the corresponding request for left shoulder arthroscopy is not medically supported, the request for postoperative physical therapy 3 times a week for 2 months is not needed. Given the lack of documentation to support guideline criteria, the request is non-certified.