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| Case Number: | CM14-0011845 | | |
| Date Assigned: | 02/21/2014 | Date of Injury: | 08/25/2008 |
| Decision Date: | 06/25/2014 | UR Denial Date: | 01/21/2014 |
| Priority: | Standard | Application Received: | 01/29/2014 |

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 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:

This 54-year-old female sustained an industrial injury 8/25/08 relative to a slip and fall. The 10/1/13 treating physician report cited continued neck pain radiating to the left arm and bilateral shoulder pain aggravated with raising the arm or heavy lifting. Cervical exam findings documented moderate upper trapezius spasms, painful and limited range of motion, and positive Spurling test with pain radiation to the left arm. Shoulder exam findings documented tenderness over the rotator cuff insertion bilaterally, symmetrical and marked loss of bilateral shoulder flexion, extension, and external rotation, mild loss of internal rotation bilaterally, and weakness and pain on resisted abduction. The left shoulder MRI revealed partial versus full-thickness tear of the supraspinatus tendon and type III acromion. The right shoulder MRI revealed a supraspinatus tear with fluid in the subscapularis bursa and a type III acromion. The cervical spine MRI showed C4/5, C5/6, and C6/7 disc bulges with compromise of the exiting nerve roots bilaterally at C5/6 and C6/7. EMG and nerve conduction study was supportive of chronic C7 nerve root irritation on the left. The treatment plan recommended a series of cervical epidural steroid injections and a nerve block, bilateral shoulder arthroscopic subacromial decompression and rotator cuff repair, pre-operative medical clearance and post-operative physical therapy. The 11/5/13, 12/10/13, and 1/14/14 handwritten progress reports are illegible, with continued surgical requests noted. The 1/21/14 utilization review denied the request for cervical epidural steroid injection based on an absence of clinical exam findings of radiculopathy supported by imaging evidence. The request for arthroscopic surgery and associate post-operative physical therapy was denied based on an absence of a specific procedure with associated clinical signs/symptoms correlated with imaging findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL EPIDURAL INJECTIONS QUANTITY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESIs) Page(s): 46.

Decision rationale: Under consideration is a request for cervical epidural steroid injection. The California MTUS supports the use of epidural steroid injections as an option for the treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Radiculopathy must be documented by physical exam and corroborated by imaging studies and/or electrodiagnostic studies and the patient should have been unresponsive to conservative treatment. Guideline criteria have not been met. This request does not specify the level(s) of injection being requested. There is no documentation of a dermatomal and/or myotomal radicular pain pattern on clinical physical examination. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for cervical epidural steroid injection is not medically necessary or appropriate.

ARTHROSCOPY SURGERY, SHOULDERS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome, Surgery for rotator cuff repair

Decision rationale: Under consideration is a request for arthroscopy surgery, shoulders. The California MTUS guidelines do not address shoulder surgeries for chronic injuries. The Official Disability Guidelines provide indications for acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test, plus imaging clinical findings showing positive evidence of impingement. Guidelines for rotator cuff repair of partial thickness tears require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for bilateral shoulder arthroscopy surgery is not medically necessary and appropriate.

POST OP PHYSICAL THERAPY QUANTITY: 36.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.