

Case Number:	CM14-0158838		
Date Assigned:	10/02/2014	Date of Injury:	02/19/2009
Decision Date:	11/06/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	09/29/2014

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 Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working atleast 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic neck, shoulder, and low back pain reportedly associated with an industrial injury of February 19, 2009. Thus far, the applicant has been treated with the following: Analgesic medications; unspecified amounts of physical therapy; and earlier cervical fusion surgery. In a Utilization Review Report dated September 16, 2014, the claims administrator denied a left shoulder open decompression surgery for rotator cuff tear and also denied three epidural steroid injections. The applicant's attorney subsequently appealed. In a September 11, 2014 progress note, the applicant reported worsening, severe neck, low back, and left shoulder pain. Positive straight leg raising was appreciated. The applicant also had a positive impingement sign about the shoulder with the flexion and abduction limited to 100 to 105 degree range. It was stated that the applicant has failed several months of conservative treatment for left shoulder rotator cuff impingement syndrome and bursal-sided rotator cuff tear. Three epidural steroid injections were also sought while Norco, Naprosyn, Flexeril, Colace, and Prilosec were renewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Open Decompression for Rotator Cuff Tear: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): TABLE 9-6, PAGE 214; 211.

Decision rationale: Yes, the proposed left shoulder open decompression for rotator cuff tear is medically necessary, medically appropriate, and indicated here. As noted in the California Medical Treatment Utilization Schedule (MTUS)-adopted American College of Occupational and Environmental Medicine (ACOEM) Guidelines in Chapter 9, table 9-6, page 211, surgery for impingement syndrome, as is present here, is usually arthroscopic decompression. Similarly, the MTUS Guideline in ACOEM Chapter 9, table 9-6 also notes that rotator cuff repair surgery is "recommended" after a firm diagnosis is made and rehabilitation efforts have been failed. In this case, the applicant has, in fact, tried and failed several months of conservative treatment with time, medications, and physical therapy, the attending provider has posited. Significant shoulder pain complaints persist. The applicant apparently has confirmed bursal-sided rotator cuff tear, the attending provider has further stated. Pursuit of a surgical remedy is indicated, given the failure of conservative treatment. Accordingly, the request is medically necessary.

L5-S1 Epidural Blocks x3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 2012-214.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

Decision rationale: The request for series of three lumbar epidural blocks at L5-S1 is not medically necessary, medically appropriate, or indicated here. As noted on page 46 of the Chronic Pain Medical Treatment Guidelines, current evidence does not support a series of three epidural blocks in either the diagnostic or therapeutic phase of treatment. Rather, page 46 of the Chronic Pain Medical Treatment Guidelines suggests that pursuit of repeat block be predicated on evidence of lasting analgesia and functional improvement with earlier blocks. The request, thus, is written, runs counter to MTUS principles and parameters as it implies pursuit of multiple injections without a provision to reevaluate the applicant between the injections to ensure a favorable response to the same. Therefore, the request is not medically necessary.