

Case Number:	CM14-0036989		
Date Assigned:	06/25/2014	Date of Injury:	06/08/2013
Decision Date:	07/25/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/27/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Oklahoma. 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 is a 61-year-old male who reported an injury on 06/08/2013 due to cumulative trauma. On 03/25/2014, the injured worker reported being unable to move his left shoulder. He denied any sensory function loss but stated that he was unable to move the extremity. A physical examination of the left shoulder revealed diffuse tenderness to palpation, restricted motion in all planes, and internal rotation to 80 degrees. Extension was not able to be performed. Impingement tests were negative in the shoulder and sulcus sign/apprehension tests were both negative. Range of motion to the left wrist was unrestricted and painless in all planes. Tinel's sign, phalen's, and finkelstein tests were all negative. An MRI (magnetic resonance imaging) of the left shoulder performed on 08/23/2013 noted supraspinatus and infraspinatus tendinosis with evidence of extensive biceps tenosynovitis with partial tearing of the biceps tendon in the bicipital groove at the pulley. There was also associated marrow edema in the lesser tuberosity and partial tearing of the upper scapular tendon with tendinosis; no full thickness rotator cuff tear was evident. There was mild glenohumeral osteoarthritis and degenerative labral tearing. The injured worker's diagnoses included left frozen shoulder syndrome, left shoulder impingement syndrome, left shoulder supraspinatus infraspinatus tendinosis, left shoulder glenohumeral degenerative osteoarthritis, left elbow lateral humeral epicondylitis, and left wrist and hand sprain. The medications included glipizide, Januvia, Norco, Tylenol number 3, and Tylenol and codeine number 4. Prior therapies included medications. The treatment plan included recommendations for a specialty evaluation with a neurology doctor, medically necessary diagnostic tests, prescribed medications, assistive durable medical equipment and/or supplies, and any injections deemed medically necessary by the

consulting physician. The request for authorization form and rationale for the treatment were not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Specialty Evaluation Neurology Doctor: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), pg. 127, and Official Disability Guidelines, Forearm, Wrist & Hand Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Office Visits.

Decision rationale: The request for specialty evaluation neurology doctor is non-certified. The requesting physician stated in a clinical note dated 03/25/2014 that the purpose of the neurology exam would be to determine whether there is actual loss of neurologic function. The CA MTUS/ACOEM guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. The Official Disability Guidelines (ODG) states that office visits are recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, and clinical stability. However, the injured worker was not noted to have any symptoms that would indicate neurologic dysfunction nor did the requesting physician specify why neurologic dysfunction was suspected. The clinical documentation provided lacks information needed to warrant a specialty evaluation by a neurologist. The request is not supported by the recommended guidelines. As such, the request is non-certified.

Medically Necessary Diagnostic Tests: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), pg. 127, and Official Disability Guidelines, Forearm, Wrist & Hand Chapter.

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

Decision rationale: The request for medically necessary diagnostic testing is non-certified. An MRI (magnetic resonance imaging) of the left shoulder was performed on 08/23/2013. The CA MTUS/ACOEM guidelines state that diagnostic testing for non-specific shoulder pain with no specific mechanism is not indicated. The requesting physician did not specify the diagnostic test

being requested, the area to be tested, or the rationale for the test. The request is not supported by the guideline recommendations. As such, the request is non-certified.

Prescribed Medications: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), pg. 127, and Official Disability Guidelines, Forearm, Wrist & Hand Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Page(s): 60-61.

Decision rationale: The request for prescribed medications is non-certified. The California MTUS guidelines state that relief of pain with the use of medication is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. The injured worker was noted to be taking multiple medications. There is no documentation regarding the efficacy of the prescribed medications. Pain relief, functional improvement, and increased activity were not addressed. In addition, the submitted request does not specify the medications, dosages, quantities, or frequencies of the medications being requested. Therefore, the request is non-certified.

Assistive Durable Medical Equipment (DME) and/or Supplies: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), pg. 127, and Official Disability Guidelines, Forearm, Wrist & Hand Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Durable medical equipment.

Decision rationale: The request for assistive durable medical equipment and/or supplies is non-certified. The Official Disability Guidelines (ODG) states that durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME). The injured worker was noted to have unrelieved pain in the left upper extremity that prevented him from moving his shoulder. The submitted request does not specify the type of equipment being requested and/or the rationale for the use of durable medical equipment. The documentation provided is lacking necessary information regarding a specific request. The request is not supported by the guideline recommendations. As such, the request is non-certified.

Any Injections Deemed Medically Necessary By The Consulting Physician: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), pg. 127, and Official Disability Guidelines, Forearm, Wrist & Hand Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: The request for any injections deemed medically necessary by the consulting physician is non-certified. The injured worker had a diagnosis of osteoarthritic degeneration of the left shoulder. The CA MTUS/ACOEM guidelines state that invasive techniques have limited proven value. For osteoarthritis, intraarticular glucocorticosteroid injections are recommended. Prolotherapy injections are not recommended. It does appear that the injured worker could benefit from the recommended injection to treat his osteoarthritic condition. However, there was no rationale given regarding the need for an injection. In addition, the requesting physician did not specify the type or site of the injections being requested. The documentation provided lacks information needed to warrant the request. As such, the request is non-certified.