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| Case Number: | CM14-0056626 | | |
| Date Assigned: | 07/09/2014 | Date of Injury: | 11/16/2012 |
| Decision Date: | 08/08/2014 | UR Denial Date: | 04/10/2014 |
| Priority: | Standard | Application Received: | 04/28/2014 |

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 47-year-old female sustained an industrial injury on 11/16/12. The mechanism of injury was not documented. Records stated that a right shoulder MRI arthrogram documented an interval tear of the right shoulder rotator cuff. The 2/14/14 orthopedic report cited grade 2/10 right shoulder aching pain with limited movement. Exam findings documented acromioclavicular joint tenderness, abduction 110 degrees, and flexion 120 degrees. The diagnosis was right shoulder rotator cuff tear and impingement syndrome. The treatment plan recommended continued physical therapy and home exercise. Right shoulder surgery authorization was pending. The 3/3/14 treating physician report cited constant grade 2/10 neck pain radiating to the right shoulder and grade 7/10 right shoulder pain, numbness and tingling. Cervical exam findings documented decreased cervical range of motion, paravertebral muscle and bilateral trapezius tenderness and spasms, and positive shoulder depression test. Right shoulder exam documented decreased shoulder range of motion and positive Hawkin's and supraspinatus press tests. There was tenderness to palpation over the posterior shoulder, acromioclavicular joint, and trapezius. The diagnosis was posttraumatic headaches, cervical sprain/strain and muscle spasms, right shoulder sprain/strain and muscle spasms, right shoulder impingement syndrome, and rotator cuff tear. The treatment plan requested aqua therapy x 12 additional sessions, cervical epidural steroid injection, and right shoulder surgery. The 4/10/14 utilization review denied the requests for right shoulder surgery, epidural steroid injection, and aquatic therapy. The request for right shoulder surgery was denied for non-specificity, lack of documented conservative treatment failure, and absence of MRI report. The request for aquatic therapy was documented as prior treatment and benefit were not documented, and there was no rationale for the medical necessity of aquatic versus land-based therapy. The request for epidural steroid injection was denied as there were no clinical exam findings of radiculopathy or corroborating imaging.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212.

Decision rationale: The ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been show to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failed conservative treatment for 3 months. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment directed to the right shoulder had been tried and failed. There is no documentation of response to recent aquatic therapy. There is no current functional assessment or evaluation of strength. There is no clear evidence of imaging findings in the records but for a statement regarding an undated shoulder MR arthrogram. There is no specific surgical procedure documented. Therefore, this request for right shoulder surgery is not medically necessary.

Aquatic therapy x12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy and Physical Medicine Guidelines Page(s): 22 & 99. Decision based on Non-MTUS Citation The Official Disability Guidelines Neck and Upper Back (updated 3/31/14); Shoulder (updated 3/31/14).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy, page(s) 22 Page(s): 22.

Decision rationale: The California Chronic Pain MTUS guidelines support the use of aquatic therapy as an optional form of exercise therapy, as an alternative to land-based physical therapy. Aquatic therapy is specifically recommended where reduced weight bearing is desirable. All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Guidelines additionally indicate that patients are instructed and expected to continue active therapies on an independent basis in order to maintain improvement levels. Guideline criteria have not been met. There is no documentation of objective measurable functional improvement with the initial 12 visits of aquatic therapy. There is no compelling reason presented to support the medical necessity of aquatic therapy over land-based therapy or independent home exercise.

The need for reduced weight bearing is not evident. Therefore, this request for 12 additional aquatic therapy sessions is not medically necessary.

1 epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection, page(s) 46 Page(s): 46.

Decision rationale: The California Medical Treatment Utilization Schedule (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. There is no clinical documentation suggestive of cervical radiculopathy. There is no documentation of cervical imaging or upper extremity electrodiagnostic testing evidencing cervical radiculopathy. The current diagnosis was documented as cervical sprain/strain and muscle spasms. There is no documentation that conservative treatment directed to the cervical spine has been tried and has failed. This request does not identify the specific spinal level(s) indicated for epidural steroid injection. Therefore, this request for one epidural steroid injection is not medically necessary.