MAXIMUS Federal Services

Case Number:	CM14-0089672		
Date Assigned:	07/23/2014	Date of Injury:	01/12/2013
Decision Date:	08/27/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/13/2014

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 Orthopaedic 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 59-year-old male sustained an industrial injury on 1/12/13. The mechanism of injury was not documented. The 5/9/13 left shoulder MRI impression documented possible anterior partial or full-thickness supraspinatus tear, degenerative supraspinatus and infraspinatus tendinosis, and acromioclavicular osteoarthritis. The 1/9/14 progress report cited left shoulder pain and indicated the patient wanted a second lumbar epidural injection. There was disc pain on deep palpation at L4/5. The treatment plan included over-the-counter medications, left shoulder arthroscopy and 2nd epidural injection at L4/5 with pain management. The 3/27/14 treating physician progress report cited continued left shoulder and L4/5 disc pain. Impingement test and left shoulder MRI were reported positive. Straight leg raise was positive on the right. Deep palpation caused pain at L4/5. The treatment plan recommended authorization for left shoulder arthroscopy and L4/5 discectomy. The 5/22/14 treating physician report cited continued left shoulder, and low back and right leg pain. Impingement test was positive in the left shoulder. There was tenderness to palpation at L4/5. The diagnosis was left shoulder impingement syndrome and lumbar spine disc protrusion. The treatment plan included left shoulder arthroscopy and pain management consult. The 6/3/14 utilization review denied the request for left shoulder arthroscopy based on an absence of documentation reflecting an appropriate course of conservative treatment, including physical therapy, injections and prescription medications. The request for pain management consultation was denied as there was no rationale for the referral, no pain assessment, and no evidence of failure of an initial trial of prescription medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management Consultation: 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127.

Decision rationale: The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. There is no current rationale presented for the pain management consult. Prior records have indicated the patient's desire for a repeat lumbar epidural injection. There is no current documentation of a lumbar radicular pain pattern or specific guideline-recommended response to prior epidural injections. There is no current pain or functional assessment. There is no indication that conservative treatment has been tried and failed, including physical therapy and prescription medications. Therefore, this request for pain management consultation is not medically necessary. llege of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127

Left Shoulder Arthroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

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 shown 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 failing conservative treatment for 3 months. The Official Disability 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. There is no evidence of abduction weakness. There is no documentation of a positive diagnostic injection test. Therefore, this request for left shoulder arthroscopy is not medically necessary.