

Case Number:	CM14-0183170		
Date Assigned:	11/10/2014	Date of Injury:	01/07/2012
Decision Date:	01/31/2015	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	11/04/2014

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 Rehab 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 patient sustained an injury on 1/7/12 while employed by [REDACTED]. Request(s) under consideration include Bilateral L4-5 Lumbar Transforaminal Epidural Injection and Orthopedic Surgery Referral for Right Shoulder. Diagnoses include s/p right shoulder arthroscopic surgery on 8/29/12. MRI of the right shoulder dated 8/26/14 showed recurrent full-thickness retracted tear of the supraspinatus tendon; moderate to severe fatty atrophy of the supraspinatus and infraspinatus muscles with partial thickness tear involving proximal biceps tendon. MRI of the lumbar spine dated 8/25/14 showed degenerative anterolisthesis 2mm at L4-5, facet arthropathy and 2 mm disc bulge resulting in mild foraminal narrowing. Report from the provider noted neck pain radiating down arm and low back pain radiating down right leg associated with weakness. Exam showed tenderness at greater tuberosity, supraspinatus and subacromial bursa; decreased sensation in radial forearm, thumb and index finger; decreased sensation at lateral leg and dorsum of foot L5; positive Spurling's on right; positive SLR on right; right shoulder with limited range; 4/5 diffuse weakness in right shoulder; lumbar spine with tenderness at iliolumbar; limited range of flex/ext of 45/15 degrees; 4/5 motor strength at ankle DF, TA and EHL and PF on right side. The request(s) for Bilateral L4-5 Lumbar Transforaminal Epidural Injection was non-certified and Orthopedic Surgery Referral for Right Shoulder was partially-certified on 10/3/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4-5 Lumbar Transforaminal Epidural Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections.

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

Decision rationale: The request for bilateral L4-5 lumbar transforaminal epidural injection was non-certified and orthopedic surgery referral for right shoulder was partially-certified on 10/3/14. MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any correlating neurological deficits or remarkable diagnostics to support the bilateral epidural injections especially when symptoms and clinical findings are noted unilaterally. The patient continues with unchanged symptom severity, unchanged clinical findings without decreased in medication profile, treatment utilization or functional improvement described in terms of increased rehabilitation status or activities of daily living for this chronic 2012 injury without evidence of functional improvement from previous conservative treatments. Criteria for the epidurals have not been met or established. The Bilateral L4-5 Lumbar Transforaminal Epidural Injection is not medically necessary and appropriate.

Orthopaedic Surgery Referral for Right Shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196.

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) Chapter 7- Independent Medical Examinations and Consultations, page 127

Decision rationale: The request for bilateral L4-5 lumbar transforaminal epidural injection was non-certified and orthopedic surgery referral for right shoulder was partially-certified on 10/3/14. Submitted reports have demonstrated possible surgical lesion with recurrent supraspinatus full-thickness retracted tear and partial thickness tear of biceps tendon on MRI along with remarkable clinical findings on exam to indicate for surgical consult as the patient has positive provocative testing, red-flag conditions and has failed conservative treatment with continued symptoms and functional limitation. The orthopedic surgery referral for right shoulder is medically necessary and appropriate.