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| Case Number: | CM15-0081654 | | |
| Date Assigned: | 05/04/2015 | Date of Injury: | 09/18/2013 |
| Decision Date: | 06/02/2015 | UR Denial Date: | 04/06/2015 |
| Priority: | Standard | Application Received: | 04/28/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 46-year-old female who sustained an industrial injury on 9/18/13. Injury was reported due to repetitive work as a nutrition services worker. The 8/14/14 left shoulder MRI impression documented minor supraspinatus and infraspinatus tendinosis/tendinitis without full thickness tear or retraction. There was mild acromioclavicular joint osteoarthritic change and synovitis without definite findings of impingement. The 8/14/14 lumbar spine MRI impression documented L4/5 disc desiccation and facet hypertrophy with overall mild neuroforaminal narrowing. There were far lateral disc osteophyte complexes with displacement of the exiting L4 nerve root on each side. The 8/20/14 bilateral lower extremity electrodiagnostic study documented findings consistent with an active lumbosacral radiculopathy. However, a specific nerve root level could not be stated due to lack of EMG findings in the lower extremity. The 3/24/15 treating physician report indicated that the patient had minimal pain improvement with physical therapy. Left shoulder exam documented range of motion as 160/160/T10 with 4+/5 strength. Neer's and Hawkin's tests were positive. Left shoulder MRI findings were positive for acromioclavicular osteophytes and biceps tenosynovitis. Lumbar spine exam documented paraspinal spasms, pain with flexion and extension, and paraspinal tenderness. The treatment plan recommended referral for evaluation and possible treatment for lumbar spine epidural steroid injections. Authorization was requested for arthroscopic left shoulder surgery for debridement and to increase range of motion in the left shoulder. The 4/8/15 utilization review non-certified the request for left shoulder surgery with arthroscopic debridement as there was no documentation of painful arc of motion, positive diagnostic injection test, or significant

abduction deficit. The request for a lumbar epidural steroid injection was non-certified as there was no documented clinical exam evidence of neurologic deficits of radiculopathy, confirmatory EMG or MRI tests, or specified levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery arthroscopy with debridement, of the left shoulder quantity: 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Conventional x-rays, AP, and true lateral or axillary view AND MRI, ultrasound, or arthrogram showing positive evidence of impingement are required. Guideline criteria have not been met. This patient presents with a history of bilateral shoulder pain. Left shoulder exam noted mild loss of range of motion with global weakness and positive impingement tests. There is imaging evidence of mild osteoarthritic changes at the acromioclavicular joint but the radiologist reported no clear evidence for impingement. There is no documentation of a positive diagnostic injection test. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

Associated service: Injection-steroid lumbar epidural, levels unspecified quantity: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection (ESIs) 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. This injured worker presents with painful range of motion and paraspinal tenderness and spasms. There is imaging evidence of L4 nerve root displacement but radiculopathy is not specifically corroborated at this level by electrodiagnostic findings. There is no documentation of signs/symptoms of radiculopathy. There are no clinical exam findings that evidence radiculopathy. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Additionally, the level for this injection has not been specified. Therefore, this request is not medically necessary.