

<b>Case Number:</b>	CM14-0187035		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	09/15/2011
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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:

According to the records made available for review, this is a 63-year-old female with a 9/15/11 date of injury, and status post right shoulder arthroscopy, decompression with acromioplasty and bursectomy, partial resection of the coracoacromial ligament and rotator cuff repair 7/29/14. At the time (10/7/14) of request for authorization for Pain management consultation, Internal medicine consultation, and associated surgical service: Physical therapy 2 x 6 for the right shoulder, there is documentation of subjective (lumbar spine pain, loss of range of motion, myospasm and weakness; right shoulder pain, loss of range of motion, myospasms, and weakness) and objective (lumbar and right shoulder edema/swelling, sensory loss in the right upper arm, lumbar trigger points) findings, current diagnoses (myofasciitis with spasm, gait abnormality, pain in lumbar, pain in right shoulder, status post right shoulder surgery), and treatment to date (activity modification, spinal cord stimulator trial, and physical therapy x 16 visits). 9/18/14 RFA identifies a request for Pain Management consultation for lumbar spine spinal stimulator and an Internal Medicine consultation pre-op, prior to lumbar spine spinal cord stimulator procedure. Regarding the requested Pain management consultation and Internal medicine consultation, there is no documentation of 50% pain relief and medication reduction or functional improvement after temporary trial. Regarding the requested associated surgical service: Physical therapy 2 x 6 for the right shoulder, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy completed to date and exceptional factors to justify going outside of guideline parameters.

### 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 base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines Chapter 7

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS) Page(s): 105-107. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and consultations, Chapter 7, page(s) 127. Official Disability Guidelines (ODG) Pain Chapter, Spinal Cord Stimulators (SCS).

**Decision rationale:** MTUS reference to ACOEM guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), primarily lower extremity pain, less invasive procedures have failed or are contraindicated, and a psychological evaluation prior to a trial, as criteria necessary to support the medical necessity of spinal cord stimulation in the management of failed back syndrome. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies that SCS is recommended as a treatment option for adults with chronic neuropathic pain lasting at least 6 months despite appropriate conventional medical management, and who have had a successful trial of stimulation, as criteria necessary to support the medical necessity of permanent spinal cord stimulation. ODG identifies documentation of 50% pain relief and medication reduction or functional improvement after temporary trial, as criteria necessary to support the medical necessity of permanent spinal cord stimulation. Within the medical information available for review, there is documentation of diagnoses of myofasciitis with spasm, gait abnormality, pain in lumbar, pain in right shoulder, status post right shoulder surgery. In addition, there is documentation of a request for Pain Management consultation for lumbar spine spinal stimulator procedure. Furthermore, there is documentation of spinal cord stimulator trial done on 6/24/14. However, there is no documentation of 50% pain relief and medication reduction or functional improvement after temporary trial. Therefore, based on guidelines and a review of the evidence, the request for Pain management consultation is not medically necessary.

**Internal medicine consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines Chapter 7

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS) Page(s): 105-107. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004)

Independent Medical Examinations and consultations, Chapter 7, page(s) 127. Official Disability Guidelines (ODG) Pain Chapter, Spinal Cord Stimulators (SCS).

**Decision rationale:** MTUS reference to ACOEM guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), primarily lower extremity pain, less invasive procedures have failed or are contraindicated, and a psychological evaluation prior to a trial, as criteria necessary to support the medical necessity of spinal cord stimulation in the management of failed back syndrome. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies that SCS is recommended as a treatment option for adults with chronic neuropathic pain lasting at least 6 months despite appropriate conventional medical management, and who have had a successful trial of stimulation, as criteria necessary to support the medical necessity of permanent spinal cord stimulation. ODG identifies documentation of 50% pain relief and medication reduction or functional improvement after temporary trial, as criteria necessary to support the medical necessity of permanent spinal cord stimulation. Within the medical information available for review, there is documentation of diagnoses of myofasciitis with spasm, gait abnormality, pain in lumbar, pain in right shoulder, status post right shoulder surgery. In addition, there is documentation of a request for an Internal Medicine consultation pre-op, prior to lumbar spine spinal cord stimulator procedure. Furthermore, there is documentation of spinal cord stimulator trial done on 6/24/14. However, there is no documentation of 50% pain relief and medication reduction or functional improvement after temporary trial. Therefore, based on guidelines and a review of the evidence, the request for Internal medicine consultation is not medically necessary.

**Associated surgical service: Physical therapy 2 x 6 for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: 9792.24. 3. Postsurgical Treatment Guidelines; and Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of myofasciitis with spasm, gait abnormality, pain in lumbar, pain in right shoulder, status post right shoulder surgery. In addition, there is documentation of status post right shoulder arthroscopy, decompression with acromioplasty and bursectomy, partial resection of the coracoacromial ligament and rotator cuff repair on 7/29/14 and at least 16 sessions of post-operative physical therapy sessions completed to date. However, there is no

documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy completed to date. In addition, given that the request is for physical therapy 2 x 6 for the right shoulder, which along with the number of visits provided to date, would exceed guidelines, there is no documentation of exceptional factors to justify going outside of guideline parameters. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service: Physical therapy 2 x 6 for the right shoulder is not medically necessary.