

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/18/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/5/2013
Date of Injury: 5/8/2012
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0007017

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]
/MCC

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Reconstructive 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator and the employee's representative
- Medical Treatment Utilization Schedule (MTUS)

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 33-year-old male who reported an injury on 05/08/2012. Per the documentation submitted for review, the patient was injured while lifting a ramp. The patient was diagnosed with a left shoulder sprain/strain, left shoulder rotator cuff tear, and impingement syndrome. The notes indicate that the patient underwent treatment with conservative means, to include injections. Also, the patient was noted to have undergone a left shoulder MRI on 06/10/2013 which showed tenosynovitis of the biceps tendon and subcoracoid bursa effusion. Also, the patient underwent a psychological evaluation on 04/02/2013 which diagnosed the patient with a depressive disorder as well as a pain disorder affecting both psychological factors and a general medical condition and which recommended psychological intervention to assist the patient in developing the resources to cope with chronic pain as well as relaxation training and cognitive behavioral therapy to assist in reducing the depressive and anxious symptoms. Physical examination of the patient was carried out on 07/01/2013, 07/09/2013, 07/29/2013 and 08/26/2013, with the notes indicating the patient to have complaints of pain, stiffness and weakness in the left shoulder. Recommendations were made for the patient to continue with psychotherapy and for the patient to continue the use of creams. On physical examination of the patient, 4/5 strength was noted, and on 07/29/2013, it was indicated that the patient was recommended for a left shoulder surgery. The notes indicate that the patient had completed physical therapy and injections with no benefits and that the patient's MRI showed impingement.

IMR DECISION(S) AND RATIONALE(S)

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

1. Cortisone Injection is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, 2nd Edition (2004), Chapter 9, page 204, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9, pages 212-214, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The ACOEM Guidelines detail the recommendation for 2 or 3 subacromial injections of local anesthetic and a coracoid steroid preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome or small tears. Repeated aspirations of corticosteroid injections are considered optional, and prolonged or frequent use of cortisone injections into the subacromial space or the shoulder joint is not recommended. The documentation submitted for review indicates the employee has undergone a prior cortisone injection with no significant benefit. Therefore, it is unclear how an additional cortisone injection would be of any treatment value to the employee. **The request for a cortisone injection is not medically necessary and appropriate.**

2. Left Shoulder Arthroscopy Decompression is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, 2nd Edition (2004), Chapter 9, page 211, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9, pages 209-211, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The ACOEM Guidelines indicate that surgical consultation may be indicated for patients who have red flag conditions, activity limitations for more than 4 months (plus the existence of a surgical lesion.) Surgical consultation may also be indicated for patients who have failed to increase range of motion and strength of the musculature around the shoulder even after exercise programs, and with clear clinical imaging evidence of a lesion shown to benefit in both the short and long-term from surgical repair. Surgery for impingement syndrome is usually an arthroscopic decompression, and the procedure is not indicated for patients with mild symptoms or those with no activity limitations. Conservative care, including cortisone injections, should be carried out for at least 3 to 6 months before considering surgery. With regards to this request, there is a lack of documentation supporting the need for surgery. Quantified ranges of motion were not provided in the documentation submitted for review. Orthopedic testing results were also not included in the medical records submitted for review. While the notes indicate that the employee has completed physical therapy as well as having had no benefit from a prior cortisone injection into the subacromial space, the length of time and procedures undertaken for conservative treatment of the employee were not provided in the notes. The imaging studies submitted for review also indicate that on 06/10/2013, the employee had evidence of tenosynovitis of the biceps tendon and subcoracoid bursa effusion. However, the acromioclavicular joint was noted to appear normal with the glenoid fossa appearing of normal marrow signal intensity and the rotator cuff muscles and tendons also appearing normal. **The request for a left shoulder arthroscopic decompression is not medically necessary and appropriate.**

3. Psych Group Therapy 4 times a month is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 101, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Psychological treatment, pages 101-102, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines indicate that psychological treatment may be recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining the appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological or cognitive function, and addressing comorbid mood disorders. Also, after identifying patients who continue to experience pain and disability after the usual time of recovery, consultation with a psychologist allows for a screening, assessment of goals and further treatment options, including brief individual or group therapy. The documentation submitted for review indicates in the clinical notes that the employee is to continue with group therapy. However, there is a lack of documentation submitted in the clinical notes indicating the employee's functional response to the previous group therapy sessions attended. **The request for Psych Group Therapy 4 times a month is not medically necessary and appropriate.**

4. Gaba-Keto 60 Grams x 2 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines section on Topical Analgesics, pages 111-113, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Topical Analgesics, pages 111-113, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The ACOEM Guidelines indicate that topical analgesics are largely experimental in use, with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include a lack of systemic side effects, absence of drug interactions and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control. However, there is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended therefore is not recommended. Ketoprofen is indicated by the guidelines as not being FDA-approved for topical application as it has an extremely high incidence of photocontact dermatitis. Likewise, gabapentin is not recommended, as there is no peer-reviewed literature to support its use. Furthermore, the documentation submitted for review indicates that the employee has been prescribed this medication for use. However, there is a lack of documentation indicated in the notes of the employee's response. Moreover, the guidelines do not support the use of gabapentin or ketoprofen in a topical

compounded medication. **The request for Gaba-Keto 60 gm times 2 is not medically necessary and appropriate.**

5. Error! Reference source not found. is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Medical Treatment Guidelines, Second Edition (2004), Chapter 9, pages 196, 207, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pages 207-209, which is part of the MTUS

The Physician Reviewer's decision rationale:

The ACOEM Guidelines indicate that the primary criteria for ordering imaging studies are (1) emergence of a red flag; (2) physiologic evidence of tissue insult or neurovascular dysfunction; (3) failure to progress in a strengthening program intended to avoid surgery and (4) for clarification of the anatomy prior to an invasive procedure. Additionally, the guidelines indicate that for most employees with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. Most employees improve quickly once red flag conditions are ruled out. Of the exceptions, stress films of the AC joints may be indicated if the clinical diagnosis is AC joint separation; if initial or recurrent shoulder dislocation presents in the dislocated position, shoulder films before and after reduction are indicated; and persistent shoulder pain associated with neurovascular compression symptoms, particularly with abduction and external rotation, may indicate the need for an AP cervical spine radiograph to identify a cervical rib. Moreover, the medical records submitted for review indicates on evaluation that on 08/26/2013, 07/29/2013, 07/09/2013 and 07/01/2013, the employee was noted to have pain to the left shoulder as well as stiffness and weakness. However, there was a lack of documentation submitted for review indicating significant red flag findings which support the recommendation for x-rays of the left shoulder. Furthermore, there is a lack of documentation indicating neurovascular dysfunction or indication that imaging studies are required for clarification of the anatomy prior to surgery or an invasive procedure. Additionally, there is no clear clinical rationale as to the necessity for an x-ray or how this may benefit the course of the employee's treatment. Additionally, it is indicated that the employee has already undergone a more detailed imaging in the form of MRI of the left shoulder, which detailed tenosynovitis of the biceps tendon and subcoracoid bursa effusion. **The request for an X-ray of the left shoulder is not medically necessary and appropriate.**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

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