
Independent Medical Review Final Determination Letter

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Dated: 12/31/2013

IMR Case Number:	CM13-0008801	Date of Injury:	04/14/2004
Claims Number:	██████████	UR Denial Date:	08/01/2013
Priority:	Standard	Application Received:	08/09/2013
Employee Name:	██████████		
Provider Name:	██████████ MD		
Treatment(s) in Dispute Listed on IMR Application:	Pain management consultation and 1 diagnostic ultrasound, bilateral shoulders		

Dear ██████████

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: PARTIAL OVERTURN. This means we decided that some (but not all) 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, ██████████

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 Physical Medicine and Rehabilitation, 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:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

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

This patient's underlying date of injury is 04/14/2004. The patient is a 54-year-old woman with the diagnosis of chronic neck pain with radiating symptoms into both shoulders and hands.

The initial reviewer noted that a pain management consultation was not medically necessary because this had been requested to determine the necessity and/or placement of epidural steroid injections, but epidural steroid injections were not being requested and because a pain management expert was not needed to proceed with a cervical MRI in order to determine the indication for an epidural steroid injection. The prior physician review also noted that guidelines support diagnostic ultrasound to help rule out a rotator cuff tear, but the records did not indicate that the patient had a rotator cuff injury but rather had referred pain to the shoulders without specific suggestion of rotator cuff involvement.

The requesting physician submitted a supplemental report on 09/19/2013 clarifying that if an epidural injection were not appropriate for the patient's condition then a pain specialist could make appropriate recommendations regarding the next best course of treatment other than epidural injections. Hence, the treating physician concluded that before requesting an epidural injection it was medically necessary to undergo a pain management specialist evaluation. Regarding diagnostic evaluation of the shoulders, the treating physician noted that the patient had a history of pain and tenderness to the shoulder with loss of range of motion, which was not specific, and therefore the treating physician requested diagnostic ultrasound for more comprehensive evaluation, particularly given the history of a right shoulder arthroscopy in 2007.

IMR DECISION(S) AND RATIONALE(S)

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

1. One (1) pain management consultation is medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 8, Neck and Upper Back Complaints (2004), pgs. 177-8, which is part of the MTUS and Chronic Pain Disorder Medical Treatment Guidelines for the state of Colorado, pg. 56, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on Epidural Injections, page Pg. 45, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Pain Management Consultation IS medically necessary.

The Chronic Pain Medical Treatment Guidelines, section on epidural injections/page 46, states, "The purpose of an epidural steroid injection is to reduce pain and inflammation, restoring range of motion, and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit." Thus, the treatment guidelines do not suggest that an epidural steroid injection would be an isolated procedure but rather that this would be part of an overall comprehensive pain management and rehabilitation program. The appeal letter from the treating physician is consistent with these guidelines in requesting a pain management consultation, not simply regarding the question of an epidural steroid injection but also regarding more overall management. The plan is consistent with the treatment guidelines. Therefore, this treatment is medically necessary.

2. One (1) diagnostic ultrasound, bilateral shoulders is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 9, pg. 209, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Diagnostic ultrasound of the bilateral shoulder IS NOT medically necessary.

The ACOEM Guidelines, Chapter 9/Shoulder, page 209, describes, "Ability of various techniques to identify and define shoulder pathology." The techniques recommended include history, physical examination, laboratory studies, and potentially plain radiography, bone scan, arthrography, computed tomography, and/or magnetic resonance imaging. These guidelines do not recommend ultrasound as a first line treatment for shoulder pathology. Moreover, the medical records are not nonspecific in terms of the differential diagnosis and the reasoning to suspect a rotator cuff tear or other condition, particularly given bilateral symptoms. This guideline would support a more detailed history and physical examination and a more specific differential diagnosis prior to considering diagnostic evaluation. The guidelines would not support the requested bilateral shoulder ultrasound studies. Therefore, this request for bilateral shoulder ultrasound is not medically necessary.

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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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CM13-0008801