

Case Number:	CM14-0007019		
Date Assigned:	02/07/2014	Date of Injury:	09/04/2013
Decision Date:	08/06/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/18/2014

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 Occupational Medicine 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:

Injured worker is a female with date of injury 9/4/2013. Per orthopedic surgeon initial consultation dated 1/21/2014, the injured worker complains of right shoulder pain anterior, lateral and scapular. She has had physical therapy and Norco, and she believes that she has lost motion. She has a history of (ORIF) Open Reduction Internal Fixation for humeral head in 2004 and following fracture and dislocation of right shoulder in 2004. On examination there is no sign of infection. There is deltoid atrophy and no migration of biceps. The scapula is stabilized. Range of motion is 65 degrees of abduction, less than 90 degrees of flexion, 55 degrees of external rotation and internal rotation to lower lumbar to the right of midline and left side upper thoracic at midline. She generates strength from neutral in internal and external rotation. There is no gross instability. There is no tenderness with AC (Acromioclavicular) joint. Diagnoses include 1) right shoulder injury in early August 2013, MR insufficient for clinical decision making 2) clinically adhesive capsulitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic), Criteria of Steroid Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 211, 213.

Decision rationale: There are no clinical notes from the requesting physician available for review. Clinical notes reviewed were by other providers. The claims administrator requested additional information that was not provided. Per the orthopedic surgeon consultation report reviewed, there is insufficient information for clinical decision making. Per the MTUS Guidelines, the use of corticosteroid injection into the subacromial bursa is a treatment option for impingement syndrome, rotator cuff inflammation, or small tears. This may be indicated for this injured worker, however, there is no clinical report providing clarification of where in the shoulder this injection would take place. The claims administrator made attempts to contact the requesting physician to find out this information specifically without success. The request for right shoulder injection is determined to not be medically necessary.

Ultrasound guidance of needle radiofrequency ablation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 300.

Decision rationale: The MTUS Guidelines and ODG do not address the use of radiofrequency ablation for treatment of shoulder injuries. The MTUS Guidelines does state that there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. The clinical documents provided for review only report a right shoulder injury and not a cervical spine injury. The clinical documents provided for review do not include any reports from the requesting physician, and the claims administrator had asked for supporting documents from the requesting physician that were not provided. The request for ultrasound guidance of needle radiofrequency ablation is determined to not be medically necessary.