

Case Number:	CM14-0129119		
Date Assigned:	08/18/2014	Date of Injury:	04/29/2010
Decision Date:	09/16/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/13/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 43-year-old female with a 4/29/11 date of injury. At the time (7/28/14) of request for authorization for MRI of the left shoulder, CT Scan of the Lumbar spine, and Left Sacroiliac joint injection under fluoroscopy, there is documentation of subjective (pain in left low back increased with prolonged sitting) and objective (lumbar range of motion limited, tenderness over the left sacroiliac joint, tenderness and crepitus of left shoulder, and left elbow tender) findings, current diagnoses (sprain of sacroiliac ligament, thoracic or lumbosacral neuritis or radiculitis, unspecified, sprains and strains of unspecified site of shoulder and upper arm, and rotator cuff syndrome of shoulder), and treatment to date (physical therapy, home exercise program, medications (including Tylenol #3), chiropractic manipulation, and activity modification). In addition, 7/16/14 medical report identifies patient has a positive Fabere's/Patrick test, sacroiliac thrust test, and Yeoman's test on the left. Regarding MRI of the left shoulder, there is no documentation of preoperative evaluation of partial thickness or large full-thickness rotator cuff tears; acute shoulder trauma, suspect rotator cuff tear/impingement; normal plain radiographs; subacute shoulder pain, or suspect instability/labral tear. Regarding CT scan of the Lumbar spine, there is no documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, and who are considered for surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment Workers Compensation (TWC) Shoulder Procedure.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

Decision rationale: The MTUS reference to ACOEM Guidelines identifies documentation of preoperative evaluation of partial thickness or large full-thickness rotator cuff tears, as criteria necessary to support the medical necessity of shoulder MRI. ODG identifies documentation of acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; subacute shoulder pain, or suspect instability/labral tear, as criteria necessary to support the medical necessity of shoulder MRI. Within the medical information available for review, there is documentation of diagnoses of sprain of sacroiliac ligaments, thoracic or lumbosacral neuritis or radiculitis, unspecified, sprains and strains of unspecified site of shoulder and upper arm, and rotator cuff syndrome of shoulder. In addition, there is documentation of objective (tenderness and crepitus of left shoulder) findings. However, there is no documentation of preoperative evaluation of partial thickness or large full-thickness rotator cuff tears. In addition, there is no documentation of acute shoulder trauma, suspect rotator cuff tear/impingement; normal plain radiographs; subacute shoulder pain, or suspect instability/labral tear. Therefore, based on guidelines and a review of the evidence, the request for MRI of the left shoulder is not medically necessary.

CT Scan of the Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment Workers Compensation (TWC) Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, CT (computed tomography).

Decision rationale: The MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of a CT. ODG identifies documentation of lumbar spine trauma (with neurological deficit, or seat belt (chance) fracture); myelopathy (neurological deficit related to the spinal cord) traumatic or infectious disease patient); to evaluate pars defect not identified on plain x-rays; and to evaluate successful fusion if plain x-rays do not confirm fusion, as criteria necessary to support the medical necessity of CT scan of the lumbar spine. Within the medical information available for review, there is documentation of diagnoses of sprain of sacroiliac ligament, thoracic or lumbosacral neuritis or radiculitis, unspecified, sprains and strains of unspecified site of shoulder

and upper arm, and rotator cuff syndrome of shoulder. In addition, there is documentation of subjective (pain in left low back increased with prolonged sitting) and objective (lumbar range of motion limited) findings, and failure of conservative treatment. However, there is no documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, and who are considered for surgery. Therefore, based on guidelines and a review of the evidence, the request for CT scan of the Lumbar spine is not medically necessary.

Left Sacroiliac joint injection under fluoroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment Workers Compensation (TWC) Hip & Pelvis.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, SI Joint Injection.

Decision rationale: The MTUS reference to ACOEM Guidelines identifies that invasive techniques are of questionable merit. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have a benefit in patients presenting in the transitional phase between acute and chronic pain. ODG identifies documentation of at least 3 positive exam findings [such as: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; and/or Thigh Thrust Test (POSH)]; diagnostic evaluation first addressing any other possible pain generators; failure of at least 4-6 weeks of aggressive conservative therapy (including PT, home exercise and medication management); block to be performed under fluoroscopy; and block not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block, as criteria necessary to support the medical necessity of SI joint injection. Within the medical information available for review, there is documentation of diagnoses of sprain of sacroiliac ligament, thoracic or lumbosacral neuritis or radiculitis, unspecified, sprains and strains of unspecified site of shoulder and upper arm, and rotator cuff syndrome of shoulder. In addition, there is documentation of at least 3 positive exam findings [Patrick's Test (FABER); Thigh Thrust Test (POSH); Yeoman's test]; diagnostic evaluation first addressing any other possible pain generators; failure of at least 4-6 weeks of aggressive conservative therapy (PT, home exercise and medication management); block to be performed under fluoroscopy; and block not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block. Therefore, based on guidelines and a review of the evidence, the request for Left Sacroiliac joint injection under fluoroscopy is medically necessary.