MAXIMUS Federal Services

Case Number:	CM14-0162146		
Date Assigned:	10/29/2014	Date of Injury:	07/10/2013
Decision Date:	12/05/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/02/2014

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:

The claimant was injured on 07/10/13. An MRI of the right shoulder, wrist-hand orthosis, and MRI of the right elbow are under review. The claimant has already had a right elbow MRI in October 2013 with pathology noted. On 09/24/14, she was evaluated for her right shoulder and right elbow. She had daily intense pain at level 10/10. She was using medications as needed for pain. She complained of spasms of the right arm that occurred 4 or 5 times per day and had frequent numbness in the right arm radiating to all of the right fingers. She could lift half a gallon. Her right arm was weaker than the left. She had been off work for 6 weeks. MRI of the right elbow dated 10/10/13 revealed a mild increased signal at the common extensor tendon at the lateral epicondyle suggesting tendinosis with a possible intrasubstance partial tear, mild thickness of the ulnar nerve, and a small effusion. She reported pain in the right shoulder. She had some depression and difficulty sleeping. Physical examination revealed that she could laterally abduct her arm to 90. Her elbow extended to 180 and flexes to 155. She was diagnosed with right shoulder impingement with a rotator cuff strain, AC joint inflammation, and biceps tendinitis, right lateral epicondylitis, and right ulnar neuritis. She also had median neuritis. MRIs of the right shoulder and right elbow were ordered due to the persistent intense pain in her elbow and shoulder. There are appeals for the MRIs and also for the soft and rigid braces for her right wrist. Her wrist was not examined. Cortisone injection to the subacromial space of the right shoulder and an injection to the right elbow were recommended. Physical therapy was also requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: The history and documentation do not objectively support the request for an MRI of the right shoulder for this injury that occurred about 1 years ago. The claimant has evidence of impingement clinically on physical examination and a subacromial injection has been recommended for impingement but it is not clear whether it has been done. The MTUS state "for most patients with shoulder problems, special studies are not needed unless a four- to six-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red-flag conditions are ruled out. There are a few exceptions: Routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears should be treated the same as impingement syndrome regardless of magnetic resonance imaging (MRI) findings.Relying only on imaging studies to evaluate the source of shoulder symptoms carries a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a finding that was present before symptoms began (for example, degenerative partial thickness rotator cuff tears), and therefore has no temporal association with the symptoms."In this case, the claimant's history of injury, evaluation, and treatment to date is unknown. It is not clear whether she has exhausted all other conservative care or whether she has been involved in an ongoing exercise program for her shoulder complaints. The medical necessity of an MRI at this time has not been clearly demonstrated.

Wrist-hand orthosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): TABLE 11-4. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Chapter 11, Forearm, Wrist, and Hand, immobilization

Decision rationale: The history and documentation do not objectively support the request for a wrist-hand orthosis. The MTUS state that immobilization may be recommended for various disorders including sprains, tendonitis, and carpal tunnel syndrome. The ODG state immobilization may be "recommended for treating displaced fractures. Immobilization is

standard for fracture healing although patient satisfaction is higher with splinting rather than casting. Treating fractures of the distal radius with casting versus splinting has no clinical difference in outcome." In this case, the indication for a wrist support for a chronic condition involving the wrist, the nature of which is unclear, has not been described and none can be ascertained from the records. The notes do not include an examination of the wrist that demonstrates instability and no focal neurologic deficits indicating the likely presence of carpal tunnel syndrome have been documented. The medical necessity of a wrist-hand orthosis has not been clearly demonstrated.

MRI of the right elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

Decision rationale: The history and documentation do not objectively support the request for an MRI of the right elbow, in this case a repeat study. The ACOEM Guidelines state "for patients with limitations of activity after 4 weeks and unexplained physical findings such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and revise the treatment strategy if appropriate. Imaging findings should be correlated with physical findings. In general, an imaging study may be an appropriate consideration for a patient whose limitations due to consistent symptoms have persisted for 1 month or more, as in the following cases: -When surgery is being considered for a specific anatomic defect. -To further evaluate potentially serious pathology, such as a possible tumor, when the clinical examination suggests the diagnosis. The claimant has a chronic condition and the injury occurred about 1 years ago. The overall history of injury, evaluation, and treatment for the right elbow is unknown. An MRI was done about a year ago and there is no evidence of a significant change in her findings to warrant repeating the study. There is no evidence of a trial and failure of a reasonable course of conservative treatment specifically for the elbow, including an exercise program, local modalities, and the judicious use of medications. There is no evidence that urgent or emergent surgery is under consideration. The medical necessity of this request for an MRI of the right elbow has not been clearly demonstrated.