MAXIMUS Federal Services

Case Number:	CM14-0043336		
Date Assigned:	06/20/2014	Date of Injury:	03/12/2010
Decision Date:	07/22/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	03/17/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas, Oklahoma. 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 injured worker is a 47-year-old male with a reported injury on 03/12/2010. The mechanism of injury was reported as performing repetitive task for his customary duties. The clinical note dated 03/03/2014 reported that the injured worker complained of bilateral shoulder pain. The physical examination revealed the injured worker had bilateral AC joint pain, left worse than right. A diagnostic study of a 4 view bilateral shoulders dated 01/31/2014 revealed acromioclavicular arthritis, intact glenohumeral. An MRI of the right shoulder revealed moderate partial rotator cuff tear, possible. An MRI of the left shoulder revealed mild partial rotator cuff tear. The injured worker's diagnoses included bilateral shoulder pain, left shoulder acromioclavicular osteoarthritis, right shoulder mild acromioclavicular arthritis, right shoulder moderate partial rotator cuff tear, and left shoulder mild partial rotator cuff tear. The provider requested 18 physical therapy sessions, 1 cortisone injection, 1 left shoulder injection with 1 cc of 0.25% Marcaine, and 1 cc of Kenalog; the rationale was to aid in the range of motion, strength, and regaining of function. The Request for Authorization was submitted on 03/14/2014. The injured worker's prior treatments included physical therapy and 3 lumbar epidural injections in 03/2011. The amount of physical therapy sessions were not provided within the clinical documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: The injured worker complained of bilateral shoulder pain. The treating physician's rationale for physical therapy is to increase range of motion and function. The CA MTUS guidelines recognize active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition is not provided. There is a lack of documentation indicating the injured worker has significant functional deficits. It is noted that the injured worker has had previous physical therapy. There is a lack of clinical notes documenting the injured worker's progression and improvement with therapy. Furthermore, the request for 18 physical therapy sessions exceeds the guidelines' recommended 8 to 10 visits over 4 weeks; therefore, the request is not medically necessary.

1 cortisone injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Steroid injections.

Decision rationale: The injured worker complained of bilateral shoulder pain. The treating physician's rationale for cortisone injection is to improve strength, function, and range of motion. The Official Disability Guidelines recommend up to three cortisone steroid injections for shoulder infections, rotator cuff disease, adhesive capsulitis, and impingement syndrome. Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; If Pain interferes with functional activities (e.g., pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management; generally performed without fluoroscopic or ultrasound guidance; only one injection should be scheduled to start, rather than a series of three. There is a lack of clinical information indicating the injured worker's pain was unresolved with conservative care to include physical therapy, home exercises, and/or medication therapy. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition was not provided. There is a lack of documentation indicating the injured worker has significant functional deficit indicating the requirement of a cortisone injection. Moreover, the requesting provider did not specify the location of the

cortisone injection being requested. The guidelines recommend this procedure to be done under fluoroscopy or ultrasound guidance; the request does not contain this recommendation. As such, the request is not.

1 left shoulder injection with 1cc of 0.25% Marcaine and 1cc of Kenalog: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Steroid injections.

Decision rationale: The injured worker complained of bilateral shoulder pain. The treating physician's rationale for Kenalog injection is to improve strength, function, and range of motion. Kenalog (Triamcinolone acetonide) is a synthetic corticosteroid with marked anti-inflammatory action, in a sterile aqueous suspension suitable for intralesional and intra-articular injection. The Official Disability Guidelines recommend up to three cortisone steroid injections for shoulder infections, rotator cuff disease, adhesive capsulitis, and impingement syndrome. Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; If Pain interferes with functional activities (e.g., pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management; generally performed without fluoroscopic or ultrasound guidance; only one injection should be scheduled to start, rather than a series of three. There is a lack of clinical information indicating the injured worker's pain was unresolved with conservative care to include physical therapy, home exercise, and/or medication therapy. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition was not provided. There is a lack of clinical documentation indicating the injured worker has significant functional deficit indicating the requirement of a Kenalog injection. Furthermore, the guidelines recommend this procedure to be done under fluoroscopy or ultrasound guidance; the request does not contain this recommendation. As such, the request is medically necessary.