MAXIMUS Federal Services

Case Number:	CM14-0060890		
Date Assigned:	07/09/2014	Date of Injury:	08/13/2004
Decision Date:	09/05/2014	UR Denial Date:	04/02/2014
Priority:	Standard	Application Received:	05/01/2014

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 patient is a 56-year-old female who has submitted a claim for complex regional pain syndrome type I of the left upper extremity, and capsulitis of the left shoulder associated with an industrial injury date of August 13, 2004. The medical records from 2005-2014 were reviewed which revealed that patient complained of left upper extremity pain, rated 5/10 in severity. There was sensitivity of the left hand and difficulty with grip strength. There was difficulty performing activities of daily living with the left upper extremity. The physical examination showed tenderness of the trapezius and rhomboids, left side greater than the right. There was decreased range of motion of the left shoulder due to pain. In addition, there was allodynia and hyperesthesia noted on the left upper extremity. The EMG/NCV of the upper extremities, dated January 4, 2005, revealed an abnormal EMG indicating bilateral C5, C6, C7 and possibly C7 nerve root impingement, chronic, mild to moderate; and abnormal NCS indicating right carpal tunnel syndrome, mild, and a mild left median motor neuropathy through the forearms.Treatment to date has included medications, home health aide, home exercise program, activity modification, stellate ganglion block, and spinal cord stimulator. The utilization review, dated April 2, 2014, denied the requests for left shoulder arthrogram and left shoulder steroid injection because there was lack of information in the records available.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthrogram: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 557-559.

Decision rationale: Per the ACOEM Guidelines referenced by CA MTUS, the criteria for imaging include a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. The MRI and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy. The MRI is more sensitive and may be the preferred investigation because it demonstrates soft tissue anatomy better. In many institutions, MR arthrography is usually necessary to diagnose labral tears. In this case, the patient has persistent left shoulder pain with reports of relief with medications and her spinal cord stimulator. Rationale for an MR arthrogram of the left shoulder was not provided. There is no objective evidence of failure of conservative treatment to relieve pain that would necessitate further imaging studies. Additionally, there were also no red flag signs noted on the most recent progress reports. The guideline states that MRI and arthrography have fairly similar diagnostic and therapeutic value. As such, the request for Left Shoulder Arthrogram is not medically necessary.

Left Shoulder Steroid Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: Per the Official Disability Guidelines (ODG), it is stated that there is limited research to support the routine use of subacromial injections for pathologic processes involving the rotator cuff, but this treatment can be offered to patients. For rotator cuff disease, corticosteroid injections may be superior to physical therapy interventions for short-term results, and a maximum of three are recommended. Subacromial injections of corticosteroids are effective for improvement for rotator cuff tendinitis up to a 9-month period. The ODG states that criteria for steroid injections include diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems; not controlled adequately by recommended conservative treatments for at least 3 months; pain interferes with functional activities; intended for short-term control of symptoms to resume conservative management; with several weeks of temporary partial resolution of symptoms and then worsening pain and function, a repeat steroid injection may be an option; and the number of injections should be limited to three. In this case, the rationale for the request was not provided. Moreover, the date of injury has been over 9 months, which is the period where corticosteroid injections will be most effective. The documentation of prior treatments to the shoulder and treatment response was not included in the records for review. There was no evidence that the patient had prior physical therapy, which is a necessary adjunct

for steroid injection. Although there were physical examination findings indicative of shoulder pathology, the MRI findings for the left shoulder were not included in the records. The guideline criteria were not met. The medical necessity cannot be established due to insufficient information. Therefore, the request for Left Shoulder Steroid Injection is not medically necessary.