

Case Number:	CM14-0067415		
Date Assigned:	07/11/2014	Date of Injury:	07/21/2010
Decision Date:	09/16/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/12/2014

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, has a subspecialty in Interventional Spine 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 43 year old with an injury date on 7/21/2010. Patient complains of intermittent left shoulder pain rated 7/10 that radiates into biceps and occasionally into triceps per 4/9/14 report. Patient takes Advil/Tylenol, uses heat/ice and also exercise bands at home per 4/9/14 report. Based on the 4/9/14 progress report provided by [REDACTED] the diagnoses are: 1. left shoulder impingement with rotator cuff strain and bicipital tendinitis 2. left wrist inflammation as well as CMC joint inflammation and STT joint inflammation which is not part of his claim. It is part of an injury on 9/30/11 Exam on 4/9/14 showed "restricted range of motion of left shoulder, especially internal rotation at 50 degrees." [REDACTED] is requesting MR arthrogram left shoulder, chiropractic treatment #12, cortisone injection left shoulder, hot/cold wrap, and a TENS unit. The utilization review determination being challenged is dated 4/29/14 and denies MRI arthrogram due to lack of prior X-ray or MRI, and the cortisone injection due to lack of documentation showing that the patient took anti-inflammatory or other medication. [REDACTED] is the requesting provider, and he provided treatment reports from 2/14/14 to 5/29/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI arthrogram left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Shoulder chapter, MR Arthrogram.

Decision rationale: This patient presents with left shoulder pain and is s/p unspecified left shoulder surgery from July 2010. The treating physician has asked for MRI arthrogram left shoulder "as patient is claustrophobic" per 4/9/14 report. No other rationale is provided. Review of the reports does not show any evidence of MRIs of the left shoulder being done in the past. Regarding MR Arthrograms, ODG shoulder chapter states they are recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. MRI is not as good for labral tears, and it may be necessary in individuals with persistent symptoms and findings of a labral tear that a MR arthrogram is performed even with negative MRI of the shoulder, since even with a normal MRI, a labral tear may be present in a small percentage of patients. Direct MR arthrography can improve detection of labral pathology. Given the patient's persistent symptoms, with no prior MRI per available reports, the treating physician's request for MR arthrogram would appear reasonable. In certain situations, MR arthrogram may be more beneficial than plain MRI's. Request is medically necessary.

Chiropractic treatments #12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guideline, Shoulder.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chapter on Manual Therapy and Treatments Page(s): 58, 59.

Decision rationale: This patient presents with left shoulder pain. The treating physician has asked for chiropractic treatment 12 sessions. Review of the reports does not show any evidence of chiropractic sessions in the patient's treatment history. MTUS guidelines allow up to 18 sessions of treatments following initial trial of 3-6 if functional improvements can be documented. In this case, the patient would appear to be indicated for a trial of up to 6 sessions of chiropractic treatment. The requested 12 chiropractic sessions, however, exceeds MTUS guidelines. Request is not medically necessary.

Cortisone injection left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: This patient presents with left shoulder pain. The treating physician has asked for cortisone injection left shoulder "for diagnostic and treatment purposes" per 4/9/14 report. Review of the reports does not show any evidence of cortisone injections to the left

shoulder being done in the past. Regarding cortisone Injections for the knee, ODG recommends for short-term use only. Only one injection should be scheduled to start, rather than a series of three. A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response. With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option. In this case, the patient has failed conservative treatments including medication, heat/ice, and home exercise program. The requested cortisone injection to the left shoulder seems reasonable and within ODG guidelines. Request is medically necessary.

Hot/Cold wrap: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: This patient presents with left shoulder pain. The treating physician has asked for hot/cold wrap. The 4/9/14 report states the patient is using a heat wrap currently. ODG shoulder chapter recommends cold packs but does not mention heat packs. For other body parts, such as low back, ODG recommends cold/heat packs for acute pain and states some evidence for heat therapy for chronic pain. ACOEM guidelines recommend at-home application of heat/cold. Given some support for these simple measures per ODG, request is deemed medically necessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy (TENS), Chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

Decision rationale: This patient presents with left shoulder pain. The treating physician has asked for TENS unit but the date of the request is not known. The patient is not currently using a TENS unit per 4/9/14 report. Regarding TENS units, MTUS guidelines allow a one month home based trial accompanied by documentation of improvement in pain/function for specific diagnosis of neuropathy, Complex Regional Pain Syndrome (CRPS), spasticity, phantom limb pain, and multiple sclerosis. In this case, the request is for a TENS unit but the patient has not yet undergone a one-month trial. The treating physician does not clarify if the request is for a purchase or a rental of the TENS unit. Due to lack of specificity of the request, request is not medically necessary.