

Case Number:	CM14-0086573		
Date Assigned:	07/23/2014	Date of Injury:	03/07/2012
Decision Date:	09/19/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/09/2014

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 Illinois. 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 63 year old female who reported injury on 03/07/2012. The mechanism of injury was not provided. Diagnoses included right shoulder partial rotator cuff tear, calcific tendonitis of the left shoulder with partial cuff tear, and bilateral rotator cuff tears with scap dysfunction of the left side greater than the right. The injured worker has had treatment including injections and physical therapy to the left shoulder only. The Physician's progress note dated 05/29/2014 noted the injured worker complained of severe stiffness and pain to her right shoulder, which was not quantified, after working three days in a row as a phlebotomist. The physical exam of the right shoulder documented positive impingement tests, forward elevation to 110 degrees, supraspinatus resistance test 4/5 and painful, external rotation at side is 4/5, negative belly press test, negative speed test, tenderness to palpation of the anterosuperior cuff, and motor and sensory function was intact distally. Medications were not documented. The treatment plan included an MRI arthrogram and ultrasound guided injection to the right shoulder. A rationale for choosing an arthrogram and injection with ultrasound guidance was not provided. The Request for Authorization form was submitted for review on 05/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Imaging arthrogram of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 202. 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 Shoulder, Arthrography, MRI.

Decision rationale: The request for Magnetic Resonance Imaging arthrogram of the right shoulder is not medically necessary. The injured worker was diagnosed with a right shoulder partial rotator cuff tear. The physical exam findings of 4/5 weakness and pain during the supraspinatus resistance test and external rotation indicate rotator cuff tears. The California MTUS and ACOEM guidelines state the preferred imaging modality for patients with suspected rotator cuff disorders is MRI with arthrogram only if MRI is unavailable. The Official Disability Guidelines further state, an MR arthrogram is recommended to detect labral tears, or a post-op re-tear of the rotator cuff. There is no documentation provided indicating an MRI would be contraindicated. The injured worker had no subjective or objective indications of a labral tear, and there was no documentation of prior right shoulder surgery. The physical exam also revealed positive impingement signs. Therefore, the request is not medically necessary.

Ultrasound guided right shoulder injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 213.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: The request for Ultrasound guided right shoulder injection is not medically necessary. The injured worker was diagnosed with a right shoulder partial rotator cuff tear. The physical exam finding of positive impingement signs to the right shoulder indicate possible impingement syndrome. The California MTUS/ACOEM guidelines state a subacromial injection of local anesthetic and a corticosteroid may be indicated after conservative therapy (i.e., strengthening exercises and non-steroidal anti-inflammatory drugs) for two to three weeks, when pain significantly limits activities. There is a lack of evidence supporting conservative therapy was provided. There is no documentation of the severity of the injured worker's right shoulder pain, or that the pain is limiting her activity. The type injection being requested is not specified to determine medical necessity. Additionally, the evidence based guidelines recommend injections for shoulder pain to be guided by anatomical landmarks alone. While ultrasound guidance may improve the accuracy of the injection to the putative site, there is no evidence to suggest an improvement in the efficacy of the injection to justify the significant added cost. Given the lack of documentation to support the need for right shoulder injection at this time, the type of injection not being indicated, and ultrasound guidance being excessive for injection of the shoulder, the request is not medically necessary.