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| Case Number: | CM14-0187878 | | |
| Date Assigned: | 11/18/2014 | Date of Injury: | 04/20/2012 |
| Decision Date: | 01/06/2015 | UR Denial Date: | 10/20/2014 |
| Priority: | Standard | Application Received: | 11/11/2014 |

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 Pain 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 injured worker is a 52 year-old male with a date of injury of April 20, 2012. The patient's industrially related diagnoses include cervical radiculitis, chronic pain, lumbar radiculitis, coccygodynia, right elbow pain, right lateral epicondylitis, bilateral shoulder pain, myofascial pain syndrome, and headaches. The injured worker had right shoulder arthroscopic acromioplasty and distal clavicle resection on 2/18/2014. The disputed issues are one subacromial cortisone injection to the right shoulder, one lateral epicondylar injection to the right elbow, and 12 physical therapy visits for the right elbow, right shoulder, and left knee. A utilization review determination on 10/21/2014 and 11/5/2014 had non-certified these requests. The stated rationale for the denial of a subacromial cortisone injection was: "The patient had previous right shoulder subacromial decompression, and continues with loss of range of motion. However, evidence-based guidelines recommend scheduling one injection to start in order to determine if there is a resolution of symptoms. A request for right shoulder diagnostic acromioclavicular joint cortisone injection was certified on 10/9/2014 in order to determine if the acromioclavicular joint is the remaining pain causing agent of the patient's shoulder pain. Based on this, a therapeutic subacromial injection is not warranted at this time." The stated rationale for the denial of a lateral epicondylar injection was: "Evidence-based guidelines indicate these injections may provide short-term benefit, but there is a lack of evidence to support their long-term effectiveness. While the patient continues with right elbow pain, there was inadequate benefit with previous injection." Lastly, the stated rationale for the denial of physical therapy was: "Evidence-based guidelines clearly do not support ongoing physical therapy if there is a lack of progress being made, and the submitted records do not demonstrate significant functional improvement to warrant addition physical therapy." On 11/5/2014, the second utilization review determination partially certified the request for physical therapy to 6 physical therapy visits for the right

shoulder and left knee. However, the physical therapy for the right elbow was denied because the injured worker was certified to have right elbow surgery, and further therapy prior to surgery would not provide significant benefit to the patient.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 subacromial cortisone injection to the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder Injection Section Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Injection Topic

Decision rationale: Regarding the request for subacromial cortisone injection to the right shoulder, Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative treatment for 2 or 3 weeks. Guidelines go on to recommend that the total number of injections should be limited to 3 per episode, allowing for assessment of benefits between injections. Official Disability Guidelines recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, or when pain interferes with functional activities. Guidelines state that a second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, there is documentation that the injured worker was approved for a right shoulder AC (acromioclavicular) joint corticosteroid injection on 10/9/2014, however there was no indication that the injection was performed. Based on the guidelines, a subacromial injection is an option for the management of shoulder pain. However, the approved AC joint injection should be completed first to identify if the right shoulder pain is generated from the AC joint before considering a subacromial cortisone injection. In light of these issues, the currently requested shoulder injection is not medically necessary.

1 lateral epicondylar injection to the right elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow (Acute & Chronic)

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

Decision rationale: Regarding the request for a lateral epicondylar injection to the right elbow, Chronic Pain Medical Treatment Guidelines are silent regarding elbow injections, so the Official Disability Guidelines were consulted. ODG states that elbow injections are not recommended as a routine intervention for epicondylitis. In the past, a single injection was suggested for short-term pain relief in cases of severe pain from epicondylitis, but the benefit was short lasting and long-term outcome was poor. Use of steroid injections to treat tennis elbow has been increasingly discouraged because of lack of long-term efficacy data and high recurrence rates. Within the submitted medical records available for review, there was documentation that the injured worker previously had physical therapy and one right elbow injection in 2013, however there was no documentation that the injection provided long-term relief. In a progress report dated 7/10/2014, the orthopedic surgeon recommended right elbow surgery after documenting that extensive conservative care had been provided, which included an injection, yet the pain persisted. Furthermore, the injured worker was approved for right elbow surgery on 10/29/2014. Based on the guidelines and in light of these issues, the requested lateral epicondylar injection is not medically necessary.

12 physical therapy visits for the right elbow, right shoulder, and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints Page(s): 200, 337-338, Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow Chapter, Shoulder Chapter, Knee & Leg Chapter, Physical Therapy

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the submitted medical records available for review, there is documentation that the injured worker completed 24 Physical Therapy (PT) sessions for the right shoulder post-operatively, but there was limited documentation of specific objective functional improvement with the previous sessions. In the progress report dated 8/18/2014, the treating physician documented that the injured worker finished his physical therapy for post-op right shoulder, but his shoulder pain was not resolved and he was no longer improving. The treating physician responded to the utilization reviewer's denial for additional physical therapy in an appeal letter dated 10/24/2014, stating that the injured worker had improvement in range of motion and reduction in pain. However, there was no additional documentation of specific examples of functional improvement. This functional improvement can include a reduction in work restrictions or other clinically significant improved function in activities of daily living. According to the Chronic Pain Medical Treatment Guidelines, continuation of physical therapy is contingent on demonstration of functional improvement from previous physical therapy.

Furthermore, in those 24 physical therapy sessions, there was ample time to instruct the injured worker on active therapies that could be continued at home in order to maintain improvement levels. The treating physician provided additional documentation regarding the previous PT for the elbow and knee. He stated that the injured worker completed 12 sessions in 2013 and indicated specific examples of functional improvement. Within the medical records, there was documentation that the injured worker was doing home exercises. However, the treating physician did not indicate why the current symptoms cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Lastly, the request exceeds the amount of PT recommended by the CA MTUS and unfortunately, there is no provision for modification of the current request. The guidelines recommend 9 visits over 8 weeks for the injured worker's knee diagnosis and 8 visits over 5 weeks for the elbow diagnosis. The second utilization review modified the request to only 6 visits for the right shoulder and left knee but denied the request for physical therapy to the elbow because a right elbow lateral release and reconstruction surgery was approved on 10/29/2014. Based on the guidelines and the medical records, the currently requested additional 12 sessions of physical therapy to the right shoulder, left knee, and right elbow is not medically necessary. The request is not medically necessary and appropriate.