

Case Number:	CM14-0188609		
Date Assigned:	11/19/2014	Date of Injury:	03/24/2010
Decision Date:	01/07/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/12/2014

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 Internal 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 (IW) is a 64-year-old woman with a date of injury of March 24, 2010. The mechanism of injury occurred when a ball hit her right shoulder, which resulted in neck whiplash. The current diagnoses include painful right shoulder subacromial impingement; and post right total shoulder arthroplasty. Treatment to date has included medications; diagnostics; total right shoulder arthroplasty, November 5, 2013; right shoulder hardware removal, November 19, 2013; and long head of biceps tenodesis. Pursuant to the most recent clinical note dated October 14, 2014, the IW complains of pain in the shoulder and numbness in the right hand with repetitive motions. Objectively, impingement tests are positive. There is tenderness of the anterosuperior cuff and anterior glenohumeral joint. Current medications include Endocet and Norco. The provider is recommending scapular based physical therapy, and an ultrasound guided subacromial cortisone injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Scapula Base Physical Therapy: Upheld

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

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

Decision rationale: Pursuant to the Official Disability Guidelines, scapular based physical therapy is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, negative direction or no direction (prior to continuing with physical therapy). The guidelines enumerated duration and frequency of physical therapy depending upon the diagnosis. See ODG guidelines. In this case, the worker is a 64-year-old woman with a date of injury March 24, 2010. Our working diagnoses are painful right shoulder subacromial impingement and posterior right total shoulder arthroplasty. Treatment has included physical therapy and medications. Physical therapy has been provided to the right arm. There is no documentation throughout the medical record indicating objective functional improvement from prior physical therapy sessions such as increased activities of daily living or reduced work restrictions, in addition to, objective evidence of improvement on physical examination. Additionally, a six visit clinical trial of PT would be appropriate (associated with the appropriate documentation). The request for scapula based physical therapy does not contain frequency and duration and consequently, is not medically necessary. Based on clinical information in the medical record and the peer-reviewed evidence-based guidelines, scapular based physical therapy is not medically necessary.

Ultrasound Guided subacromial cortisone injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 204. 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); Shoulder Section, Ultrasound Guidance

Decision rationale: Pursuant to the Official Disability Guidelines, ultrasound guided subacromial cortisone injection is not medically necessary. In the shoulder, conventional anatomical guidance by an experienced clinician is generally adequate. While ultrasound guidance may improve the accuracy of injection the putative site of pathology, it is not clear that this improves its efficacy. In this case, a subacromial injection of local anesthetic and cortisone preparation may be indicated after conservative therapy. The guidelines recommend cortisone injections for individuals with impingement syndrome that fails to respond to conservative treatment. However, cortisone injections are generally performed without ultrasound guidance. Conventional anatomical guidance by an experienced clinician is generally adequate and ultrasound guidance does not improve the accuracy of the injection to the putative site. Consequently, ultrasound guided subacromial cortisone injection is not medically necessary.