MAXIMUS Federal Services

Case Number:	CM15-0004089		
Date Assigned:	01/15/2015	Date of Injury:	01/31/2013
Decision Date:	03/11/2015	UR Denial Date:	12/19/2014
Priority:	Standard	Application Received:	01/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 65 year old male, who sustained an industrial injury on 1/31/2013. The diagnoses have included rotator cuff syndrome, lumbar spondylolisthesis and disk bulges, right lumbar radicular pain, and bursitis. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), neurontin, muscle relaxer, physical therapy, lumbar medial branch blocks, right knee surgery 7/10/14 .Currently, the Injured Worker complains of continued pain in right knee, pain, numbness, and acute spasms in bilateral SI joints, and increased left shoulder pain. Physical examination from 1/26/15 documented positive shoulder impingement, positive Faber's test and decreased strength left shoulder, decreased range of motion in all planes on exam of lower back and negative straight leg raise. Plan of care included therapeutic injection to bilateral SI joint, and injection of left shoulder joint, consult to orthopedics, and continue current medications.On 12/19/2014 Utilization Review non-certified a bilateral SI joint injection under ultrasound, Magnetic Resonance Imaging (MRI) left shoulder, left shoulder injection with 5cc 1% Lidocaine and 40mg Kenelog. Utilization review noted a left shoulder Magnetic Resonance Imaging (MRI) completed 5/9/14, however, medical records did not provide documented results, and Magnetic Resonance Imaging (MRI) report was not submitted for review. The MTUS, ACOEM, and ODG Guidelines were cited.On 1/8/2015, the injured worker submitted an application for IMR for review of bilateral SI joint injection under ultrasound, Magnetic Resonance Imaging (MRI) left shoulder, left shoulder injection with 5cc 1% Lidocaine and 40mg Kenelog.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral SI joint injection under ultrasound: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition, 2014, Hip & Pelvis, Sacroiliac Joint Blocks

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Society of Interventional Pain Physicians: Comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations Source: http://www.guideline.gov/content.aspx?id=45379#Section420

Decision rationale: There is limited research-based evidence or random controlled studies to endorse or disapprove use of corticosteroid injections for care of sacroiliac pain. According to ACOEM and American Society of Interventional Pain Physicians guidelines, injection of these medications should be reserved for patients who do not improve with more conservative therapies. There is better research-based evidence to consider cooled radiofrequency neurotomy when considering more invasive sacroiliac treatments. The crux of the decision for this patient is whether or not the patient has sacroiliac disease and whether the patient has been given an adequate trial of non-invasive treatment before moving on to injection therapies. The provider has not documented exam findings or made a diagnosis consistent with sacroiliac disease. The patient also has not been given an adequate trial of non-invasive therapy. At this point in this patient's care medical necessity for this procedure has not been established.

MRI left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition, 2014, Shoulder, Magnetic Resonance Imaging (MRI)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Chapter 9, page(s) 196-203, 207-9, 214. Decision based on Non-MTUS Citation American College of Radiology, Appropriateness Criteria for Imaging Acute Shoulder Pain, Revised 2010

Decision rationale: Magnetic Resonance Imaging (MRI) is a procedure performed in radiology to assess the body by clarifying the anatomy of the region tested. It can identify acute injuries (eg fractures, dislocations, infections), mechanical injuries (ligament or tendon strains), degenerative disorders (arthritis, tendinitis) or masses, tumors or cysts. ACOEM guidelines as well as the guidelines published by the American College of Radiology suggest using this procedure to evaluate the shoulder when plain films of the shoulder are negative, symptoms suggest a surgically correctable condition and/or the patient has failed rehabilitation efforts. Review of the available medical records on this individual reveals signs and symptoms of

shoulder impingement for which the patient had an MRI done 9 months ago which showed a partial supraspinatus tendon tear and tendinosis of supraspinatus and infraspinatus tendons. Even though conservative treatment to date has not resolved the symptoms, at this point in this patient's care since the patient has had neither additional trauma or signs/symptoms that would indicate a change in the patient's anatomic findings from the prior MRI nor is surgery being considered by the requesting provider, repeating the MRI is not indicated. Medical necessity has not been established.

Left shoulder injection with 5cc 1% Lido and 40mg Kenalog: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints Page(s): Chapter 3, page(s) 48; Chapter 9, page(s) 204, 211, 213.

Decision rationale: There is limited research-based evidence or random controlled studies to endorse or disapprove use of corticosteroid injections for care of shoulder pain. According to ACOEM guidelines, injection of these medications should be reserved for patients who do not improve with more conservative therapies. However, there is enough evidence to consider these injections (up to 3 times) when other therapies have not been helpful, especially when the only other treatment being offered is surgery. The crux of the decision for this patient is whether or not the patient has been given an adequate trial of non-invasive treatment before moving on to injection therapies. Not all the medical notes are available for review but the documentation does not add new evidence that there has been an adequate trial of non-invasive treatment in that physical therapy or exercise for the shoulder was performed. Medical necessity for this procedure has not been established.