

Case Number:	CM15-0133609		
Date Assigned:	08/18/2015	Date of Injury:	12/14/2014
Decision Date:	09/14/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/10/2015

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 55 year old female who sustained an industrial injury to her right shoulder on 12-14-2014 when she was hit with a metal grill gate. The injured worker was diagnosed with traumatic right shoulder impingement syndrome with tendonitis, supraspinatus tendonitis, complete rotator cuff tear and mild osteoarthritis of the acromioclavicular joint. Treatment to date has included diagnostic testing with X-rays of the right shoulder on June 10, 2015, physical therapy (12 completed) modified duties, Toradol intramuscularly, steroid injections to the right shoulder and medications. According to the primary treating physician's progress report on June 10, 2015, the injured worker continues to experience right shoulder and scapular pain with radiation to the right arm rated at 4 out of 10 on the pain scale. Examination demonstrated tenderness to palpation over the anterior shoulder, acromioclavicular joint, acromion and greater tuberosity. Range of motion was decreased, painful and positive for crepitation. Deep tendon reflexes and sensation were intact. Motor strength was noted at 4 out of 5 of the right upper extremity muscle groups. Neer's, arch or rotation, thumbs down and Hawkins tests were positive. Tinel's and Phalen's at the elbows were negative. Current medications are listed as Tramadol, Ultram ER, Prilosec and topical medications. Treatment plan consists of the authorized right shoulder arthroscopy for rotator cuff repair and subacromial decompression with pre-operative medical clearance and bloodwork and post-operative physical therapy times 12 and the current request for retrospective request for right shoulder trigger point injection (DOS: 6-10-15) and cold therapy unit for 10 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO: Trigger point injection-Right shoulder (DOS 6/10/15) Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, Trigger point injections, page 122 states, "Recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. Physical examination must document a twitch response on palpation with referred pain. There must be no physical exam, imaging or electrodiagnostic evidence of a possible radiculopathy." In this case the exam notes from 6/10/15 demonstrate no evidence of myofascial pain syndrome. Therefore the determination is for non-certification and therefore is not medically necessary.

Cold therapy unit (days) Qty: 10.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous-flow Cryotherapy.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case the requested length of time for the cryotherapy unit exceeds 7 days. Therefore the determination is for non-certification and therefore is not medically necessary.