

Case Number:	CM15-0195533		
Date Assigned:	10/09/2015	Date of Injury:	02/19/2015
Decision Date:	12/11/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	10/05/2015

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: Emergency 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 47 year old female who sustained an industrial injury on February 19, 2015. A recent primary treating office visit dated September 10, 2015 reported subjective complaint of "no change in the right shoulder since last visit." She reports using Naproxen BID and Flexeril as needed as night. There is note of consulting doctor with recommendation for right shoulder injection. The following diagnosis was applied to the visit: right shoulder internal impingement. The plan of care is with concurring recommendation for a right shoulder corticosteroid injection ultra sound guided additional physical therapy session and scapulothoracic bracing. The following were prescribed this visit: Flexeril and Naproxen. Follow up dated June 22, 2015 reported medication regimen consisting of: Ativan, Ambien, Flexeril, and Naproxen. On September 03, 2015 a request was made for 12 session of physical therapy, additional treating right shoulder; corticosteroid injection to right shoulder, and scapulothoracic positional brace that were noncertified by Utilization Review on September 17,2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Scapulothoracic positioning brace (Spinal Q), Qty 1: 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): Shoulder - Immobilization.

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

Decision rationale: The request is for a scapulothoracic brace. The official disability guidelines state the following regarding this topic: Not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. (Nash, 2004) With the shoulder, immobilization is also a major risk factor for developing adhesive capsulitis, also termed "frozen shoulder". An RCT was done to ascertain whether immobilization after primary traumatic anterior dislocation of the shoulder in external rotation was more effective than immobilization in internal rotation in preventing recurrent dislocation, but it was about the same, with 37% from the external rotation group and 42% from the internal rotation group sustaining a further dislocation. (Finestone, 2009) See also postoperative abduction pillow sling. In this case, there is inadequate documentation of the reasoning for use or the indication. As stated above, immobilization is not advised as a primary treatment due to the risk for developing complications including adhesive capsulitis. As such, the request is not medically necessary.

Physical therapy, right shoulder, 2 times weekly for 6 weeks, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic)/Physical therapy.

Decision rationale: The request is for physical therapy of the shoulder. The official disability guidelines state the following regarding this topic: OGD Physical Therapy Guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the OGD Preface. Rotator cuff syndrome/Impingement syndrome: Medical treatment: 10 visits over 8 weeks Post-injection treatment: 1-2 visits over 1 week Post-surgical treatment, arthroscopic: 24 visits over 14 weeks Post-surgical treatment, open: 30 visits over 18 weeks Complete rupture of rotator cuff : Post-surgical treatment: 40 visits over 16 weeks Adhesive capsulitis: Medical treatment: 16 visits over 8 weeks Post-surgical treatment: 24 visits over 14 weeks Dislocation of shoulder: Medical treatment: 12 visits over 12 weeks Post-surgical treatment (Bankart): 24 visits over 14 weeks Acromioclavicular joint dislocation: AC separation, type III+: 8 visits over 8 weeks Sprained shoulder; rotator cuff: Medical treatment: 10 visits over 8 weeks Medical treatment, partial tear: 20 visits over 10 weeks Post-surgical treatment (RC

repair/acromioplasty): 24 visits over 14 weeks Superior glenoid labrum lesion: Medical treatment: 10 visits over 8 weeks Post-surgical treatment (labral repair/SLAP lesion): 24 visits over 14 weeks Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified): Medical treatment: 9 visits over 8 weeks Post-injection treatment: 1-2 visits over 1 week Post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks Brachial plexus lesions (Thoracic outlet syndrome): Medical treatment: 14 visits over 6 weeks Post-surgical treatment: 20 visits over 10 weeks Fracture of clavicle: 8 visits over 10 weeks Fracture of scapula: 8 visits over 10 weeks Fracture of humerus: Medical treatment: 18 visits over 12 weeks Post-surgical treatment: 24 visits over 14 weeks In this case, passive physical therapy is not indicated. The records do not indicate pain and functional improvement seen with previous physical therapy performed. At home, active therapy is suggested. As such, the request is not medically necessary.

Corticosteroid subacromial injection, right shoulder, Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic)/Steroid injections.

Decision rationale: The request is for a shoulder corticosteroid injection to aid in pain relief. The official disability guidelines state the following regarding this topic: Criteria for Steroid injections: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (eg, pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management; Generally performed without fluoroscopic or ultrasound guidance; Only one injection should be scheduled to start, rather than a series of three; second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three. In this case, this treatment is not guideline-supported. This is secondary to inadequate documentation of conservative treatments performed over at least a 3 month period. As such, the request is not medically necessary.

Ultrasound, Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation URL [www.ncbi.nlm.nih.gov/pubmed/16357546].

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic)/Steroid injections.

Decision rationale: The request is for a shoulder corticosteroid injection under ultrasound guidance to aid in pain relief. The official disability guidelines state the following regarding this topic: Criteria for Steroid injections: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (eg, pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management; Generally performed without fluoroscopic or ultrasound guidance; Only one injection should be scheduled to start, rather than a series of three; second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three. In this case, this treatment is not guideline-supported. This is secondary to inadequate documentation of conservative treatments performed over at least a 3 month period. An ultrasound performed for this purpose would also not be indicated. As such, the request is not medically necessary.