MAXIMUS Federal Services

Case Number:	CM15-0027166		
Date Assigned:	02/19/2015	Date of Injury:	09/19/2013
Decision Date:	04/07/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	02/12/2015

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: Physical Medicine & Rehabilitation

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 45 year old female, who sustained an industrial injury on September 19, 2013. Her diagnoses include left shoulder impingement and possible quadrilateral space syndrome. She has been treated with intra-articular injection, MRI in 2013, electrodiagnostic studies, cortisone electrophoresis, and pain and non-steroidal anti-inflammatory medications. On January 20, 2015, her treating physician reports left shoulder pain due to a flu vaccination into the posterior aspect of the shoulder. She was treated with physiotherapy, intra-articular steroid injection, acupuncture, and various pain and non-steroidal anti-inflammatory medications. The pain persisted despite these treatments. Current medication includes and non-steroidal anti-inflammatory medication. The physical exam revealed mildly decreased range of motion, tenderness to palpation of the supraspinatus, no instability, mildly decreased strength, normal sensation, normal reflexes, and positive impingement testing. The treatment plan includes an MR angiogram and physiotherapy for the left shoulder. On February 12, 2015, the injured worker submitted an application for IMR for review of a left shoulder MR angiogram rule out humeral circumflex artery impingement quadrilateral space syndrome and 12 sessions (2 times a week for 6 weeks) of physical therapy. The MR angiogram was non-certified based on lack of rationale form the treating provider. The physical therapy was non-certified based on lack of documentation of what functional benefit was received from prior physical therapy sessions, and lack of documentation of ness deficits that would support supervised physical therapy versus a home exercise program. The California Medical Treatment Utilization Schedule (MTUS):

Chronic Pain Medical Treatment Guidelines and Non- Medical Treatment Utilization Schedule (MTUS) guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder MR angiogram R/O humeral circumflex artery impingement quadrilateral space syndrome: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2488174. HSSJ 2006 Sep; 2(2) 154-156 Published on line 2006 July; Quadrilateral Space Syndrome caused by Humeral Osteochondroma.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter under MR arthrogram.

Decision rationale: According to the 01/20/2015 report, this patient presents "for comprehensive orthopedic second-opinion surgical consultation." The patient presents with persistent "left shoulder pain as the result of a flu vaccination injection." The current request is for Left shoulder MR angiogram R/O humeral circumflex artery impingement quadrilateral space syndrome. The request for authorization is on 01/30/2015. The patient's work status in the meantime is to remain on disability status per [redacted]. Regarding MR Arthrogram, ODG guidelines state "Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair." It further states, "MRI is not as good for labral tears, and it may be necessary in individuals with persistent symptoms and findings of a labral tear that a MR arthrogram be performed even with negative MRI of the shoulder, since even with a normal MRI, a labral tear may be present in a small percentage of patients. Direct MR arthrography can improve detection of labral pathology. (Murray, 2009) If there is any question concerning the distinction between a full-thickness and partial-thickness tear, MR arthrography is recommended." Review of the reports show that the patient had a "bursal-surface partial-thickness supraspinatus tendon tear, irregularity at the muscle-tendon junction of the infraspinatus consistent with mild partial tearing" per MRI report on 09/23/2014. In this case, the requested MR arthrogram appears reasonable given partial tear of RCT, and additional evaluation of labral tear. The request IS medically necessary.

Physical Therapy quadrilateral space syndrome: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines: Passive therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: According to the 01/20/2015 report, this patient presents "for comprehensive orthopedic second-opinion surgical consultation." The patient presents with persistent "left shoulder pain as the result of a flu vaccination injection." The current request is for physical therapy quadrilateral space syndrome. For physical medicine, MTUS guidelines pages 98, 99 state that for myalgia and myositis, 9-10 visits are recommended over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. In reviewing of provided reports show that the patient has had 14 physical therapy sessions from 04/18/2014 to 08/25/2014. Per the 08/25/2014 physical therapy report the patient had "limited ability to perform stretching and strengthening of her shoulder due to her pain being out of control. Her shoulder progression has halted due to her pain that may be compensatory from her GHJ dysfunction." In this case, given that the patient had completed 14 PT sessions recently, the requested additional physical therapy sessions without specifying the number of sessions requested is not supported by MTUS. Therefore, the request IS NOT medically necessary.