

Case Number:	CM15-0050310		
Date Assigned:	03/23/2015	Date of Injury:	02/22/2010
Decision Date:	05/01/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/17/2015

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 (IW) is a 66-year-old female who sustained an industrial injury on 02/22/2010. Diagnoses include left upper extremity ulnar nerve involvement with cubital tunnel syndrome and carpal tunnel syndrome, left shoulder impingement and cervical strain. Treatment to date has included medications, cortisone injections to the left wrist and fingers. Diagnostics performed to date included electrodiagnostics. There was no MRI to review. According to the Comprehensive Orthopedic Evaluation dated 8/6/14, the IW reported pain and numbness in the left upper extremity, going to her neck. A request for DME (electric heat pad) and MRI of the left shoulder was made for treatment and diagnosis of left shoulder pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: electric heat pad: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back Chapter, heat therapy.

Decision rationale: The patient was injured on 02/22/10 and presents with pain in the left upper extremity, pain in the neck, left arm pain, left wrist pain, and left elbow pain which goes up to the left shoulder and arm. The request is for a DME ELECTRIC HEAT PAD. There is no RFA provided and the patient is currently working. The report with the request is not provided. ODG Low Back Chapter has the following regarding heat therapy, "Recommended as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain." ODG further states, "Active warming reduces acute low back pain during rescue transport. Combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control." ODG also supports heat as a method of pain reduction for knee complaints, also. The reason for the request is not provided. The patient is diagnosed with left upper extremity ulnar nerve involvement with cubital tunnel syndrome and carpal tunnel syndrome, left shoulder impingement, and cervical strain. In this case, the patient does not present with low back pain or with knee pain, as indicated by ODG Guidelines. Due to lack of support from guidelines, the requested electric heat pad IS NOT medically necessary.

MRI of the left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official disability guidelines Shoulder chapter, MRI.

Decision rationale: The patient was injured on 02/22/10 and presents with pain in the left upper extremity, pain in the neck, left arm pain, left wrist pain, and left elbow pain which goes up to the left shoulder and arm. The request is for a MRI OF THE LEFT SHOULDER. There is no RFA provided and the patient is currently working. The report with the request is not provided. ACOEM Guidelines has the following regarding shoulder MRI on pages 207-208, "routine testing (laboratory test, plain film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first 6 weeks of activity limitation due to shoulder symptoms except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain." ACOEM Guidelines page 207-208 continues to state that the primary criteria for ordering imaging studies include: 1. Emergency red flags. 2. Physiologic evidence of tissue insult. 3. Failure to progress in strengthening program. 4. Clarification of anatomy prior to an invasive procedure. The ODG Guidelines under shoulder chapter support MRI of the shoulder if conservative measures have failed and rotator cuff/labral tear are suspected. Regarding the left shoulder, the patient has a limited range of motion, a positive provocative test, and the patient complains of pain with attempts to place the left arm behind the back. The patient is diagnosed with left upper extremity ulnar nerve involvement with cubital tunnel syndrome and carpal tunnel syndrome, left shoulder impingement, and cervical strain. The

reason for the updated MRI is not provided. Review of the reports provided does not indicate if the patient had a prior MRI of the left shoulder. Given that the patient has a limited left shoulder range of motion, is diagnosed with left shoulder impingement, and continues to have left shoulder pain, an MRI appears reasonable and supported by the guidelines. The requested MRI of the left shoulder IS medically necessary.