

Case Number:	CM15-0083738		
Date Assigned:	05/05/2015	Date of Injury:	05/01/2014
Decision Date:	06/05/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	04/30/2015

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 was a 65-year-old female, who sustained an industrial injury, May 2, 2014. The injured worker was diagnosed with left subacromial bursitis and supraspinatus partial tear, lumbar disc herniation or degenerative disc disease causing foraminal stenosis and left L5-S1 radiculopathy. The injured worker previously received the following treatments physical therapy (for the left shoulder, neck and low back), MRI (cervical, lumbar and left shoulder), chiropractic services, medication (Tramadol, Relafen, Prilosec, Norflex, Norco, Valium), home exercise program, and steroid injection in the left shoulder. According to progress note of March 30, 2015, the injured worker's chief complaint was left shoulder pain, which radiated to the neck and lower back pain with radiation to the left posterolateral thigh. The injured worker's physical therapy to the shoulder, neck and lower back and leg was without effective symptom relief. The injured worker denied any numbness or tingling in the left arm. The lower back pain ran down into the leg with associated numbness and tingling in the left foot. The MRI of the left shoulder showed partial tear of the supraspinatus tendon and subacromial bursitis. The MRI of the cervical spine showed a mild disc bulges throughout. However, there was no evidence of any disc herniations causing impingement of nerve roots. According to the progress note of April 3, 2015, the injured worker rated the low back pain at 7-8 out of 10, constant sharp. The left shoulder pain was rated as 7 out of 10. The left lower extremity the pain was rated as 6 out of 10. The physical exam noted limited range of motion to the lumbar spine due to guarding and pain, with associated numbness and weakness with a variable intensity. The treatment plan included lumbar spine MRI, referral to pain management for ultrasound guided left supraspinatus injection and subacromial injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-4, 309. Decision based on Non-MTUS Citation American College of Radiology, Appropriateness Criteria for the Imaging of Lower Back Pain, Revised 2011.

Decision rationale: Magnetic Resonance Imaging (MRI) scans are medical imaging studies used in radiology to investigate the anatomy and physiology of the body in both healthy and diseased tissues. MRIs of the lower back are indicated in acute injuries with associated "red flags", that is, signs and symptoms suggesting acutely compromised nerve tissue. In chronic situations, the indications rely more on a history of failure to improve with conservative therapies, the need for clarification of anatomy before surgery, or to identify potentially serious problems such as tumors or nerve root compromise. When the history is non-specific for nerve compromise but conservative treatment has not been effective in improving the patient's symptoms, electromyography (EMG) and nerve conduction velocity (NCV) studies are recommended before having a MRI done. This patient does meet the criteria of prolonged or persistent symptoms despite conservative care but the patient had a lumbar MRI in Nov 2014. There has not been new onset of any red flag symptoms nor interval history of new trauma to the lower back that would suggest a change to the anatomy of that area of the body. At this point in the care of this individual, a MRI of the lower back is not indicated. Medical necessity for this procedure is not medically necessary.

Referral to pain management: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Acoem page 92,127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): Chp 2 pg 21, Chp 5 pg 79, 89-90, 92.

Decision rationale: Decision on when to refer to a specialist is based on the ability of the provider to manage the patient's disease. It relates to the provider's comfort point with the medical situation and the provider's training to deal with that situation. In this case, the provider has a patient with chronic pain, not improved with conservative care. His referral to a pain specialist to manage the patient's chronic pain is appropriate if he does not feel comfortable

doing the management. This is implied when a provider requests a referral. Medical necessity is medically necessary.

Ultrasound guided left supraspinatus injection and subacromial injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints Page(s): Chp 3 pg 48; Chp 9 pg 204, 213. Decision based on Non-MTUS Citation Optimizing the Management of Rotator Cuff Problems - Guideline and Evidence Report Adopted by the American Academy of Orthopaedic Surgeons, Board of Directors. December 4, 2010.

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 therapies that are more conservative. 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 are surgery. Neither the ACOEM guideline nor the American Academy of Orthopaedic Surgeons guideline recommends ultrasound guidance for these injections. Medical necessity for use of ultrasound to guide the proposed steroid injection is not medically necessary.