

Case Number:	CM14-0094499		
Date Assigned:	08/06/2014	Date of Injury:	03/18/2004
Decision Date:	09/19/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/20/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 57 year old female who reported injuries to both shoulders and carpal tunnels. The utilization review dated 08/13/14 resulted in denials for an MRI of the right shoulder, injections at the right shoulder, an MRI of the left shoulder, as well as a brace to address carpal tunnel syndrome, and chiropractic therapy. Additionally, a modified certification was provided for an injection at the left shoulder. The qualified medical examination dated 03/13/12 indicates the injured worker complaining of neck, low back, bilateral shoulder, and right wrist pain following a period of heavy equipment use due to her job as a landscaper. The note indicates the injured worker having undergone several episodes of physical therapy. The electrodiagnostic studies completed on 02/01/13 revealed essentially normal findings. No evidence of a mononeuropathy, radiculopathy, or plexopathy was identified. The MRI of the left shoulder dated 03/15/13 indicates the injured worker having tendinosis at the supraspinatus and infraspinatus. The clinical note dated 06/20/14 indicates the injured worker complaining of mid-back, low back, right wrist, and left shoulder pain. There is an indication the injured worker had undergone an MRI of the left shoulder which revealed tendonitis. The note indicates the injured worker having returned to work. The injured worker reported difficulty concentrating on her job secondary to the pain levels. The note indicates the injured worker having undergone a subacromial injection of Depomedrol and Xylocaine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of Right Shoulder Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: The documentation indicates the injured worker complaining of bilateral shoulder pain. An MRI of the shoulder is indicated provided the injured worker meets specific criteria to include completion of all conservative treatments along with significant functional deficits associated to the shoulder. No information was submitted regarding the injured worker's range of motion or strength deficits at the right shoulder. Additionally, it is unclear if the injured worker has completed any conservative treatments addressing the right shoulder complaints. Given these factors, the request is not indicated as medically necessary.

MRI of Left Shoulder Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: The documentation indicates the injured worker having previously undergone an MRI of the left shoulder. A repeat MRI of the shoulder is indicated provided the injured worker meets specific criteria to include significant changes identified in the injured worker's symptomology or new pathology having been discovered by clinical exam. No information was submitted regarding the injured worker's significant changes at the left shoulder. Therefore, this request is not indicated as medically necessary.

Fluoroscopy for Injections of Bilateral Shoulders Qty: 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

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, Injections.

Decision rationale: There is an indication the injured worker had previously been approved for an injection at both shoulders. A 2nd injection would be indicated provided the injured worker meets specific criteria to include a significant functional improvement following the initial injection. No objective data was submitted confirming the injured worker's positive response to the previous injection. As such, the request is not medically necessary.

Subacromial Space Injections Right Shoulder Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

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, Injections.

Decision rationale: No information was submitted regarding the injured worker's significant functional deficits at the right shoulder. Therefore, it is unclear how the injured worker will benefit from a subacromial injection at the right shoulder at this time. Therefore, this request is not indicated as medically necessary.

Retro: Carpal Tunnel Brace Qty:1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chapter 11, regarding Forearm, Wrist and Hand Complaints Page(s): 265-266. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC, 10th Edition, Treatment Index, Carpal Tunnel Syndrome (Updated 05/07/2013).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Chapter, Splints.

Decision rationale: The submitted electrodiagnostic studies revealed no significant carpal tunnel involvement. Additionally, no information was submitted regarding provocative findings confirming the injured worker's carpal tunnel involvement. Therefore, it is unclear how the injured worker was to benefit from the use of a carpal tunnel brace. As such, the request is not medically necessary.

Chiro/Physiotherapy Qty: 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Physical Medicine, Manual Therapy & Manipulations Page(s): 58-60 & 98-99.

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, Physical Medicine.

Decision rationale: There is an indication the injured worker has undergone physical therapy in the past. However, no objective data was submitted confirming the injured worker's positive response to the previously rendered treatments. Therefore, it is unclear if the injured worker will benefit from additional therapeutic treatments at this time. Therefore, this request is not indicated as medically necessary.

