

Case Number:	CM15-0112390		
Date Assigned:	06/24/2015	Date of Injury:	07/14/2014
Decision Date:	08/25/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	06/10/2015

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 55-year-old female who sustained an industrial injury on 07/14/2014 to the right shoulder. Diagnoses include right shoulder large partial articular surface-sided rotator cuff tear; exuberant subdeltoid bursitis; superior labral tear; rupture of the long head of the biceps tendon; moderate acromioclavicular joint arthritis of the right shoulder; and status post right shoulder cortisone injection with positive response. Treatment to date has included medications, heat and ice application, physical therapy and cortisone injections. MRI of the right shoulder on 8/20/14 found a partial articular surface-sided tear of the supraspinatus tendon and moderate infraspinatus tendinosis; a full-thickness subscapularis tendon tear; rupture of the long head of the biceps tendon; chronic degenerative tearing of the superior labrum and scarring of the inferior capsule; small glenohumeral joint effusion, debris and synovitis; narrowing of the subacromial space and moderate acromioclavicular arthrosis; and marked subacromial subdeltoid bursitis with a large bursal fluid collection with internal debris. According to the progress notes dated 2/2/15, the IW reported moderate right shoulder pain radiating into the elbow, hand and fingers. Symptoms were described as constant and included swelling, tingling, locking, burning pain, popping, grinding, stiffness, stabbing pain, weakness, catching and tenderness. She stated heat and ice application were helpful. On examination, the right subacromial region of the right shoulder was tender to palpation with a positive impingement sign. A request was made for physical therapy once a week for six weeks for the right shoulder and acupuncture once a week for six weeks for the right shoulder; open MRI for the shoulder; range of motion test once per month; and electromyography/nerve conduction velocity (EMG/NCV) studies of the bilateral extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture one times six for the right shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines Page(s): MTUS pg. 13 of 127, 8.

Decision rationale: The patient was injured on 07/14/14 and presents with right shoulder pain with weakness which radiates to the arm, hand, fingers, and back. The request is for acupuncture one times six for the right shoulder. The utilization review denial letter did not provide a rationale. There is no RFA provided and the patient was "released to modified work on February 2, 2015. No pushing, pulling, or lifting over 10 lbs. No overhead work." The report with the request is not provided. Review of the reports provided does not indicate if the patient has had any prior acupuncture sessions. For acupuncture, MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial, and with functional improvement, 1 to 2 per month. For additional treatment, MTUS Guidelines require functional improvement as defined by Labor Code 9792.20(e), a significant improvement in ADLs, or change in work status and reduced dependence on medical treatments. The patient is tender subacromially and has a positive impingement sign. She is diagnosed with right shoulder large partial articular surface-sided rotator cuff tear, exuberant subdeltoid bursitis, superior labral tear, rupture of the long head of the biceps tendon, moderate acromioclavicular joint arthritis of the right shoulder, and status post right shoulder cortisone injection with positive response. Treatment to date includes medications, heat and ice application, physical therapy, and cortisone injections. In this case, there is no indication that the patient has had any prior acupuncture sessions. The requested 6 sessions of acupuncture appears medically reasonable and is within MTUS guidelines. The request is medically necessary.

Open MRI for the shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter under MRI.

Decision rationale: The patient was injured on 07/14/14 and presents with right shoulder pain with weakness which radiates to the arm, hand, fingers, and back. The request is for open MRI for the shoulder. There is no RFA provided and the patient was "released to modified work on February 2, 2015. No pushing, pulling, or lifting over 10 lbs. No overhead work." The report with the request is not provided. The patient had a MRI of the right shoulder conducted on 08/20/14 which revealed a partial articular surface-sided tear of the supraspinatus tendon and moderate infraspinatus tendinosis; a full-thickness subscapularis tendon tear; rupture of the long head of the biceps tendon; chronic degenerative tearing of the superior labrum and scarring of the inferior capsule; small glenohumeral joint effusion, debris and synovitis; narrowing of the subacromial space and moderate acromioclavicular arthrosis; and marked subacromial subdeltoid bursitis with a large bursal fluid collection with internal debris. ACOEM Guidelines has the following regarding shoulder MRI on pages 207-208, "Routine testing (laboratory tests, 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 supports MRI of the shoulder if conservative measures have failed and rotator cuff/labral tear are suspected. The reason for the request is not provided. The patient is tender subacromially and has a positive impingement sign. She is diagnosed with right shoulder large partial articular surface-sided rotator cuff tear, exuberant subdeltoid bursitis, superior labral tear, rupture of the long head of the biceps tendon, moderate acromioclavicular joint arthritis of the right shoulder, and status post right shoulder cortisone injection with positive response. Treatment to date includes medications, heat and ice application, physical therapy, and cortisone injections. The patient had a prior MRI of the right shoulder on 08/20/14 and the treater does not discuss why another set of MRI's are needed. In this case, there are no significant changes and symptoms and/or findings, which are suggestive of significant pathology. The patient is not post-op either. Therefore, the requested updated MRI of the shoulder is not medically necessary.

Range of motion test one times month: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter under Functional Improvement Measures.

Decision rationale: The patient was injured on 07/14/14 and presents with right shoulder pain with weakness which radiates to the arm, hand, fingers, and back. The request is for a range of motion test one times month. There is no RFA provided and the patient was released to modified work on February 2, 2015. No pushing, pulling, or lifting over 10 lbs. No overhead work. The report with the request is not provided. MTUS guidelines page 48 does discuss functional improvement measures where physical impairments such as "joint ROM, muscle flexibility, strength or endurance deficits" include objective measures of clinical

exam findings. It states, "ROM should be documented in degrees." ODG-TWC, Pain Chapter under Functional Improvement Measures states that it is recommended. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. The following category should be included in this assessment including: Work function and/or activities of daily living, physical impairments, approach to self-care and education. The reason for the request is not provided. The patient is tender subacromially and has a positive impingement sign. She is diagnosed with right shoulder large partial articular surface-sided rotator cuff tear, exuberant subdeltoid bursitis, superior labral tear, rupture of the long head of the biceps tendon, moderate acromioclavicular joint arthritis of the right shoulder, and status post right shoulder cortisone injection with positive response. Treatment to date includes medications, heat and ice application, physical therapy, and cortisone injections. Range of Motion measurements can be easily obtained via clinical examination. ODG guidelines recommend range of motion testing and muscle testing as part of follow-up visits and routine physical examination. However, Range of Motion testing is not recommended as a separate billable service. Therefore, the request is not medically necessary.

EMG/NCV bilateral upper extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 206.

Decision rationale: The patient was injured on 07/14/14 and presents with right shoulder pain with weakness which radiates to the arm, hand, fingers, and back. The request is for an EMG/NCV bilateral upper extremity. The utilization review denial letter did not provide a rationale. There is no RFA provided and the patient was "released to modified work on February 2, 2015. No pushing, pulling, or lifting over 10 lbs. No overhead work." The report with the request is not provided. Review of the reports provided does not indicate if the patient had a prior EMG/NCV of the bilateral upper extremities. ACOEM Guidelines page 206 states: "appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions such as cervical radiculopathy. This may include nerve conduction studies (NCS) or in more difficult cases, electromyography (EMG) may be helpful. EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later and the course of treatment if symptoms persist. ODG Guidelines on the neck and upper back (acute and chronic) chapter under the section called EMG states that EMG is recommended as an option in select cases. ODG further states regarding EDS in carpal tunnel syndrome, recommended in patients with clinical signs of CTS and may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), with the additional electromyography (EMG) is not generally necessary. The reason for the request is not provided. The patient is tender subacromially and has a positive impingement sign. She is diagnosed with right shoulder large partial articular surface-sided rotator cuff tear, exuberant subdeltoid bursitis, superior labral tear, rupture of the long head of the biceps tendon, moderate acromioclavicular joint arthritis of the right shoulder, and status post right shoulder cortisone injection with positive response. Treatment to date includes medications, heat and ice application, physical therapy, and cortisone injections. Given that the patient has positive exam findings and continues to have right shoulder pain which radiates to the arm, hand, fingers, and back, an EMG/NCV appears reasonable. An EMG/NCV study may help the treater pinpoint the cause and location of the patient's symptoms. Therefore, the requested EMG/NCV for the bilateral upper extremity is medically necessary.