

Case Number:	CM15-0123545		
Date Assigned:	07/08/2015	Date of Injury:	02/09/2011
Decision Date:	08/04/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	06/26/2015

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, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

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 sustained an industrial injury on 2/9/2011. She reported a pop and pain in her right shoulder. Diagnoses have included right shoulder impingement, right shoulder acromioclavicular arthrosis, right elbow medial and lateral epicondylitis and left shoulder impingement. Treatment to date has included chiropractic treatment, acupuncture and two to three corticosteroid injections to the right shoulder with temporary relief. According to the progress report dated 5/13/2015, the injured worker complained of pain in her right shoulder. She described constant, aching pain with pins and needles. The pain radiated back into the shoulder blade and up into the neck. She rated the pain as 9/10. She also complained of right elbow pain with weakness rated 9/10. Exam of the right shoulder revealed swelling and diffuse tenderness to palpation. There was pain with range of motion. Testing showed positive Neer's, Hawkin's, Speed and Cross Arm tests. Exam of the left shoulder revealed diffuse tenderness to palpation and pain with range of motion. Testing revealed positive Neer's, Hawkin's and Cross Arm tests. The injured worker underwent bilateral shoulder steroid injections at the visit. The treatment plan was for right shoulder arthroscopic surgery. Authorization was requested for bilateral shoulder epidural steroid injection and post-op cold compression therapy for two weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Bilateral shoulder epidural steroid injection (ESI): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for the use of ESI Page(s): 80, 382-383.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injection Page(s): 46.

Decision rationale: According to the CA MTUS/ Chronic Pain Medical Treatment Guidelines, Epidural Steroid injections page 46, The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There must be evidence that the claimant is unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). In this case the exam notes from 5/13/15 do not demonstrate a radiculopathy that is specific to a dermatome on physical exam. In addition there is lack of evidence of failure of conservative care. Therefore the request is not medically necessary.

Associated surgical service: Cold compression therapy for 2 weeks: Upheld

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

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case the requested duration exceeds the guideline recommendations and the request is therefore not medically necessary.