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**March 5, 2018**

**IRO CASE #: XXXX**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Depo-Medrol injection

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** Pain Management Physician

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a XXXX who was injured on XXXX. XXXX sustained an injury to XXXX left shoulder. The patient worked as a XXXX and the XXXX than it should be for XXXX, so XXXX had to perform most of XXXX work XXXX.

On XXXX, the patient was evaluated by XXXX, for the complaints of the left shoulder pain. The patient started experiencing pain with XXXX at work. XXXX had one injection in the past and had tried physical therapy (PT) but could not complete the therapy secondary to pain. Currently, XXXX described the pain as a moderate, burning and aching. XXXX had painful clicking and popping in XXXX shoulder. XXXX also complained of numbness, stiffness, and tingling in XXXX left upper extremity. XXXX pain was worse after the hand use and while driving XXXX left hand overhead. XXXX reported feeling better when XXXX kept XXXX arm below XXXX shoulder height. The examination of the left shoulder revealed biceps tenderness. The range of motion (ROM) was normal. The biceps muscle strength was 4/5, and the supraspinatus and subscapularis strength was 5/5. Hawkin's test was negative. The sensation was normal. Speed's and Yergason's tests were positive. Outside images were reviewed. X-rays of the left shoulder were normal. A computed tomography (CT) of the left shoulder was also normal. A magnetic resonance imaging (MRI) of the left shoulder showed increased fluid around the biceps tendon. There was some mild increased T2 signal in the supraspinatus tendon consistent with tendinosis versus partial tearing. The diagnosis was left long head biceps tendinitis. XXXX opined surgery was not necessary for the condition and recommended injection in the left biceps tendon sheath.

On XXXX, a pre-certification was submitted for the left shoulder injection. The diagnosis was left shoulder impingement.

Per a correspondence dated XXXX, the requested left biceps tendon sheath Depo-Medrol injection between XXXX and XXXX was noncertified. (Incomplete Report)

Per a correspondence dated XXXX, XXXX was notified about the denial. It was documented

XXXX, performed a utilization review on XXXX, and denied the request for left biceps tendon sheath Depo-Medrol injection between XXXX and XXXX. Rationale: *“As noted with the recent MRI of the upper extremity completed, there was no specific objective data demonstrating any significant inflammatory response. There was a slight increase in fluid around the biceps tendon. However, there were changes noted in the supraspinatus as well. Furthermore, it is not clear what, if any, conservative care, relative to the biceps tendon findings, has been presented. Lastly, a previous injection protocol was not noted to be efficacious. Therefore, this speaks against a repeat of this procedure. This request is not clinically indicated and is recommended for non-certification.”*

Per correspondence dated XXXX, XXXX was notified about the denial of the appeal. It was noted that XXXX, performed reconsideration on XXXX, and upheld the denial. Rationale: *“The patient has had XX of physical therapy in XXXX and has used naproxen for pain. XXXX has had an injection to the shoulder by another orthopedic doctor in the past with only 1 day of relief reported. The exact nature of that injection is unknown. After review of the submitted documentation and evidence-based treatment guidelines, it appears that the prior determination was appropriate. Guidelines support steroid injections for those with specific shoulder conditions who have failed to respond to conservative treatment; however, a second injection is not recommended if there was no response to the first injection. While it appears that the patient suffered from continued shoulder pain and has had appropriate conservative care attempted to date to address XXXX bicep tendon symptoms, there is no significant documented response to the prior injection. The exact nature of the prior injection is not completely clear; however it was a shoulder injection performed to improve XXXX current symptoms per the available records. With the above in mind, the guideline criteria have not been met. Therefore, the requested appeal for left bicep tendon sheath Depo-Medrol injection is non-certified.”*

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The patient continues with left shoulder pain despite conservative care as per available records. The denials for the request for a left shoulder depo-medrol biceps injection were based on the ODG and the fact that the patient had a previous injection that provided one day of relief. However, the exact nature, i.e. location of the prior injection is unclear. No records are available that document the specific site of the injection.

The guidelines do support steroid injections for shoulder conditions that fail to respond to conservative care. It is documented that the patient continues to have pain and is not able to progress in therapy. A magnetic resonance imaging (MRI) of the left shoulder showed increased fluid around the biceps tendon. The physical examination corroborates the MRI findings.

Given the lack of conclusive evidence as to the exact location of the previous injection, the efficacy of said injection, or lack thereof cannot be definitively established. Therefore, I would defer to the treating physician’s recommendation. The left bicep depo-medrol injection is certified.

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**