

Case Number:	CM14-0130671		
Date Assigned:	08/20/2014	Date of Injury:	04/22/2009
Decision Date:	12/31/2014	UR Denial Date:	08/03/2014
Priority:	Standard	Application Received:	08/15/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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 patient is a 55 year old male with date of injury 04/22/09. The treating physician report dated 07/02/14 indicates that the patient presents with insomnia, right shoulder, bilateral wrist, cervical and lumbar spine pain. Prior treatment history includes X-Rays, MRI of the bilateral hands and wrists, pain medications, and a course of physical therapy for one month with no relief back in April 2009. Prior treatment history also included in July 2013, X-Rays, MRI and EMG/NCV of the neck, low back, bilateral wrist/hand and right shoulder, pain medications and a course of physical therapy for one month with no relief. The physical exam also indicates reduced ROM in the right shoulder and wrist/hand. The current diagnoses are: 1. Herniated cervical disc C5-6 2. Right shoulder sprain/strain positive MRI3. Right wrist strain/sprain 4. Right hand strain/sprain 5. Left hand strain/sprainThe utilization report dated 08/03/14 denied the request for ultrasound guided cortisone injection to right wrist and shoulder based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound guided cortisone injection to right wrist: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Wrist, Hands, and Forearm Chapter

Decision rationale: The patient presents with insomnia, right shoulder, bilateral wrist, cervical and lumbar spine pain. The current request is for ultrasound guided cortisone injection to right wrist. The ACOEM guidelines do not recommend cortisone injections for nonspecific wrist pain. The ODG guidelines recommend steroid injections only for trigger finger and for de Quervain's tenosynovitis. In this case the treating physician has requested a right wrist injection that is not supported by ODG or ACOEM. Recommendation is for denial.

Ultrasound guided cortisone injection to right shoulder: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Shoulder Chapter, Steroid Injections

Decision rationale: The patient presents with insomnia, right shoulder, bilateral wrist, cervical and lumbar spine pain. The current request is for Ultrasound guided Cortisone Injection to right shoulder. The ACOEM guidelines page 213 recommend cortisone injections for the treatment of rotator cuff inflammation, impingement syndrome or small tears. The ODG guidelines states there must be a "Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (eg, pain with elevation is significantly limiting work)." In this case there is a diagnosis of a shoulder strain, there is documented courses of physical therapy, and there is documentation of pain interfering with functional activities. Recommendation is medically necessary.