

Case Number:	CM14-0046019		
Date Assigned:	07/02/2014	Date of Injury:	11/04/2013
Decision Date:	08/15/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/14/2014

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 Interventional Spine 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 58 years old female with an injury date on 11/04/2013. Based on the 03/24/2014 progress report provided by [REDACTED], the diagnoses are: 1. Thumb joint inflamed 2. Shoulder pain 3. Disorder of bursa of shoulder region According to this report, the patient complains of frequent right shoulder pain that is aching, stabbing, and sharp. The patient states lifting, computer use, changing clothes and sleeping would aggravate the pain. Also the patient reports that the pain can radiate down the right forearm area laterally with pushing, pulling and computer use. Examination of the shoulder indicates positive impingement sign, shrug sign, and adduction test. Tenderness was noted at the greater tuberosity and right AC joint. A MRI on 03/05/2014 reveals mild supraspinatus tendinitis, no rotator cuff tear is identified and mildly AC joint hypertrophic change. There were no other significant findings noted on this report. [REDACTED] is requesting ultrasound with subacromial cortical steroid injection and physical therapy 2 times a week for 4 weeks. The utilization review denied the request on 04/01/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 01/26/2014 to 03/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound with subacromial corticosteroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Chapter: Steroid Injections.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG) Shoulder Chapter.

Decision rationale: According to the 03/024/2014 report by [REDACTED] this patient presents with frequent right shoulder pain. The treater is requesting ultrasound with subacromial cortical steroid injection. ODG guidelines do not support U/S guidance with shoulder injection as multiple studies have yet to demonstrate much benefit with patient outcome. Recommendation is for denial.

Auth #2 Physical Therapy 2 x 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines pages 98, 99 Physical Medicine Page(s): 98, 99.

Decision rationale: According to the 03/024/2014 report by [REDACTED] this patient presents with frequent right shoulder pain. The treater is requesting 8 sessions of physical therapy. For physical medicine, the MTUS guideline recommends for myalgia and myositis type symptoms 9-10 visits over 8 weeks. Review of the reports show the patient had completed 10 of the 12 authorized physical therapy sessions for the shoulder. The treater states "previous PT did not help." The treater does not mention why additional therapy is needed when prior therapy did not help. No discussion is provided as to why the patient is not able to perform the necessary home exercises. The requested 8 sessions plus the 12 authorized exceed what is allowed by MTUS guidelines. Recommendation is for denial.