

Case Number:	CM14-0085421		
Date Assigned:	07/23/2014	Date of Injury:	07/09/2011
Decision Date:	09/15/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/09/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 injured worker is a 36 year old female injured on 07/09/11 due to an undisclosed mechanism of injury. Diagnoses include persistent pain and inflammation of the right shoulder, recurrent posterior-inferior humeral subluxation, and post right shoulder arthroscopy, posterior capsular labral repair on 01/23/12. Prior treatment included physical therapy, medication management, surgical intervention, physical therapy, and diagnostic studies to include X-rays, EMG/NCV study, and MRI. Clinical note dated 05/02/14 indicates the injured worker presented complaining of pain in the right shoulder aggravated with overhead reaching and overhead work. Physical examination of the right shoulder revealed decreased range of motion and subacromial grinding and clicking in the right shoulder. Clinical note dated 05/13/14 indicates the injured worker presented reporting no change since previous visit and utilizing medication to help manage symptoms. Medications include Tramadol. Examination revealed pain with impingement test, decreased range of motion, pain with jerk test, supraspinatus resistance test 4/5, belly press test negative, speed test negative, palpation demonstrates tenderness biceps, motor and sensory function intact distally, negative tension signs, and reflexes not tested. Treatment plan included selective ultrasound guided injections to biceps to confirm pain generator, continuation of Tramadol, and initiation of physical therapy. The initial request for ultrasound guidance for injection to the right bicep was initially non-certified on 05/22/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound guidance for injection, right bicep: Overturned

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

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, injections.

Decision rationale: The request for Ultrasound guidance for injection, right bicep is medical necessary. Given the physical examination findings, prior surgery, persistent pain, medical necessity has been established. Therefore, this request is medically necessary.