

<b>Case Number:</b>	CM15-0000938		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	08/28/2012
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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  
 Certification(s)/Specialty: Family Practice

### 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 51 year old female, who sustained an industrial injury on 8/28/2012. The mechanism of injury has not been provided with the clinical documentation submitted for review. The diagnoses have included cervicgia, lumbago and unspecified neuralgia, neuritis and radiculitis. Treatment to date has included medications and chiropractic care. Currently, the IW complains of back pain. Objective physical examination revealed tenderness over the bilateral splenius, capitis/cervicis muscles, facet joints, medial scapular muscles and upper trapezius muscles. Range of motion of neck is limited due to stiffness. Straight leg raise test is positive. There is tenderness to palpation at the mid-thoracic level. Range of motion of the lumbar spine is limited due to pain and stiffness. Range of motion of the bilateral shoulders is diminished overall due to pain. Magnetic resonance imaging (MRI) of the lumbar spine dated 12/21/2012 showed 4-5mm disc bulges, multilevel ligamentous hypertrophy and spondylosis and MRI of the cervical spine dated 12/21/2012 showed degenerative disc disease at C5-6 and C6-7. On 12/31/2014, Utilization Review non-certified prescriptions for right shoulder joint steroid injection and x-rays of the bilateral hands/wrists noting the lack of established medical necessity. The ACOEM Guidelines were cited. On 1/02/2015, the injured worker submitted an application for IMR for review of right shoulder joint steroid injection and x-rays of the bilateral hands/wrists.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Joint Steroid Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 204.

**Decision rationale:** According to guidelines it states corticosteroid injections are recommended for impingement syndrome. according to medical records there is no diagnosis of impingement syndrome. Thus it is not medically necessary.

**X-Rays Bilateral Hands/Wrists:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258-260.

**Decision rationale:** According to guidelines it states "If there are no red flags present to indicate serious conditions, the clinician can then determine which common musculoskeletal disorder is present." Xrays are indicated if there is non-specific pain due to trauma, overuse, or other pathology. According to medical records there is no documentation that meets these guidelines and thus is not medically necessary.