

Case Number:	CM15-0100492		
Date Assigned:	06/02/2015	Date of Injury:	09/17/2014
Decision Date:	07/01/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	05/26/2015

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: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 37-year-old male sustained an industrial injury on 9/17/14. He subsequently reported right wrist and hand pain. Diagnoses include right wrist sprain and strain. Treatments to date include MRI and x-ray testing, chiropractic care, physical therapy and prescription pain medications. The injured worker continues to experience right wrist and hand pain. Upon examination, right wrist range of motion is decreased and painful, Phalen's causes pain. A request for Injection (unspecified type/bodypart/dosage) and Re-evaluate as needed Qty: 1.00 was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Injection (unspecified type/bodypart/dosage): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 193-19, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Chapter 9, Shoulder Complaints, pages 204, 207; Table 9-6, page 213.

Decision rationale: The patient was evaluated for diagnosis of right shoulder AC joint DJD. Illegible report noted consideration of future injection without formal request or specifics for injection. There is no specific failed conservative treatment noted to meet criteria of corticosteroid injection nor has there been clear documented functional improvement by way of ADLs or decrease in medication dosing or medical utilization to support current request. Guidelines states if pain with elevation is significantly limiting activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and NSAIDs) for two to three weeks, but the evidence is not yet overwhelming, and the total number of injections should be limited to no more than three. Although injections into the subacromial space and acromioclavicular joint can be performed in the clinician's office, injections into the glenohumeral joint should only be performed under fluoroscopic guidance. A recent meta-analysis concluded that subacromial corticosteroid injection for rotator cuff disease and intra-articular injection for adhesive capsulitis may be beneficial although their effect may be small and not well maintained. Additionally, for post-traumatic impingement of the shoulder, subacromial injection of methylprednisolone had no beneficial impact on reducing the pain or the duration of immobility. Submitted reports have not specified limitations with activities or functional improvement from previous treatment to support for this unspecified shoulder injection. The Injection (unspecified type/bodypart/dosage) is not medically necessary and appropriate.

Re-evaluate as needed Qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Request was modified for one re-evaluation visit. Guidelines state office visits and follow-ups are determined to be medically necessary and play a critical role in the proper diagnosis and treatment based on the patient's concerns, signs and symptoms, clinical stability along with monitoring of medications including opiates. Determination of necessity requires individualized case review and assessment with focus on return to function of the injured worker. Submitted reports have not adequately demonstrated acute symptoms or red flag conditions and clinical findings to allow for continued arbitrary follow-up intervention and care and future care with multiple visits cannot be predetermined, as assessment should be made according to presentation and clinical appropriateness. The patient continues to treat for chronic symptoms without any acute flare, new injury, or progressive deterioration to predict future outcome; undetermined quantity of follow-up visits is not medically indicated for this chronic injury. The Re-evaluate as needed Qty: 1.00 is not medically necessary and appropriate.