

Case Number:	CM15-0168541		
Date Assigned:	09/09/2015	Date of Injury:	06/18/2012
Decision Date:	10/07/2015	UR Denial Date:	08/04/2015
Priority:	Standard	Application Received:	08/27/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 39 year old male who sustained an industrial injury on 06-18-12. A review of the medical record indicates that the injured worker is undergoing treatment for a right upper extremity injury resulting in shoulder pain and myofascial pain syndrome. Medical records (07-13 to 07-17-15) indicate right side lifting-carrying has increased from 4 pounds to 7 pounds, right side activities of daily living participation has increased from less than 1 minute to 4 minutes and 45 seconds from 04-14-15 to 07-17-15. Also noted are right crush grip strength of 110 pounds, sitting and walking tolerance of 60 minutes, standing tolerance of 25 minutes, and lifting-carrying tolerance of 31 pounds. There is no physical exam in the submitted documentation. Diagnostic studies are not addressed. Treatment has included narcotic medications and a Functional Restoration Program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder injection qty: 1.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Steroid injections.

Decision rationale: The claimant sustained a work injury in June 2012 and continues to be treated for right shoulder pain. Recent treatments include participation in a functional restoration program. There is a progress report dated 07/21/15. He had been seen for a pre-scheduled orthopedic evaluation for the right shoulder on 07/15/15. A right shoulder injection had been recommended and is being requested. A steroid injection is recommended as an option which shoulder pain is not controlled adequately by recommended conservative treatments including physical therapy, exercise, and medications after at least three months. Criteria include a diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems. In this case, the type of injection and diagnosis for which it is being requested were not submitted. For example, a subacromial injection could be appropriate for rotator cuff impingement but not for osteoarthritis of the glenohumeral joint. Whether the injection could be considered an appropriate treatment for the claimant's condition cannot be determined. The request that was submitted cannot be accepted as being medically necessary and therefore is not medically necessary.