

Case Number:	CM15-0208456		
Date Assigned:	10/29/2015	Date of Injury:	03/07/2015
Decision Date:	12/21/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/22/2015

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: Florida
 Certification(s)/Specialty: Neurology, 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 59 year old female, who sustained an industrial injury on 03-07-2015. She has reported injury to the head, nose, chest, right shoulder, and right arm. The diagnoses have included trauma brain injury; nose contusion with internal derangement; chest wall contusion; post-traumatic myofascial pain syndromes; and right shoulder contusion and rotator cuff injury. Treatment to date has included medications, diagnostics, activity modification, and home exercise program. Medications have included Mobic and Flexeril. A progress note from the treating physician, dated 10-29-2015, documented a follow-up visit with the injured worker. The injured worker reported pain in the chest, right arm and shoulder, and nose; she also feels dizziness; intermittent chest pain with radiation to the chest wall; it is a dull pain that is moderate in severity; occasional and constant pain in the right arm and shoulder and nose with radiation to the elbow and shoulder; numbness sensation in the arm; the pain is an aching and stabbing pain; and the pain is rated at 8 out of 10 in intensity. Objective findings included no tenderness or swelling was noted to the right shoulder, chest wall, and nose; range of motion was decreased in the right shoulder; motor strength was 5- out of 5 in the right upper extremity; and right shoulder rotator cuff stress test was positive. The treatment plan has included the request for E-Ac (electro-acupuncture) 2x a week for 3 weeks, infrared, myofascial release; and cortisone injection x1 to the right shoulder. The original utilization review, dated 10-09-2015, non-certified the request for E-Ac 2x a week for 3 weeks, infrared, myofascial release; and cortisone injection x1 to the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

E-Ac 2x a week for 3 weeks, infrared, myofascial release: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: MTUS guidelines do not support the use of electrical stimulation for the treatment of pain for which E-AC is a form of electrical stimulation treatment. The medical records indicate pain but do not otherwise document any medical condition for which electrical stimulation is supported for treatment under MTUS guidelines. As such E-ac is not supported as medically necessary.

Cortisone injection x1 to the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

Decision rationale: The medical records provided for review do not document the presence of at least 3 positive physical examination findings supportive of shoulder joint dysfunction and does not document the failure of at least 4-6 weeks of conservative treatment including PT or home exercises. ODG supports Shoulder joint block with: 1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). 2. Diagnostic evaluation must first address any other possible pain generators. 3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. As such the medical records provided for review do not support medical treatment of shoulder injection. The request is not medically necessary.