

<b>Case Number:</b>	CM14-0128766		
<b>Date Assigned:</b>	08/18/2014	<b>Date of Injury:</b>	08/09/2012
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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 Physical Medicine and Rehabilitation 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 patient is a 52 year old female who was injured on 08/09/2012. The mechanism of injury is unknown. She has received physical therapy but there was no improvement in her symptoms. Prior medication history included Meloxicam, Metformin, vitamin D3 and Voltaren Gel. The patient underwent manipulation under anesthesia, debridement of the shoulder joint, bursectomy with acromioplasty on 03/05/2014. Progress report dated 04/25/2014 states the patient presented 6 weeks from acromioplasty of her right shoulder. The patient was taking Meloxicam which was helping her symptoms. On exam, she has 100 degrees of active flexion; 137 degrees in the supine position. She moved from 0-30 degrees of external rotation. The patient was recommended for additional physical therapy and a cortisone injection to the right wrist as she has a diagnosis of tenosynovitis as noted on report dated 05/14/2014. Prior utilization review dated 07/09/2014 by [REDACTED] states the request for right wrist cortisone injection times 2 under ultrasound guidance is modified to right wrist cortisone injection times 1 without ultrasound guidance as medical necessity has not been established.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Request for right wrist cortisone injection x 2 under ultrasound guidance:** 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): 263-265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Wrist and Forearm, Injection

**Decision rationale:** Guidelines state that injection is recommended for acute/subacute tenosynovitis. Ultrasound guidance was not mentioned in the guidelines for wrist injection, thus I agree with the prior utilization review to modify the request from right wrist cortisone injection times 2 under ultrasound guidance to right wrist cortisone injection times 1 without ultrasound guidance as medical necessity has not been established. The medical necessity is not established for right wrist cortisone injection times 2 under ultrasound guidance.