

Case Number:	CM14-0149009		
Date Assigned:	09/18/2014	Date of Injury:	09/16/2011
Decision Date:	11/05/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	09/12/2014

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 Orthopedic Surgery 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:

Claimant with reported industrial injury on 9/16/11. Report from 8/13/14 is made of shoulder pain with normal range of motion with positive impingement sign and 4+/5 rotator cuff strength. No documentation is noted of conservative care for the right shoulder. Claimant is reported to be status post right wrist surgery 4 months prior per report of 8/13/14. Claimant is reported to have undergone post surgical therapy of unknown amount without report of functional improvement. Magnetic resonance imaging (MRI) right wrist on 10/17/13 demonstrates distal radioulnar joint osteoarthritis and effusion. A tear of the triangulofibrocartilage complex is noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Section: Forearm, Wrist & Hand (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: According to the California Medical Treatment Utilization Schedule (MTUS)/ACOEM guidelines Chapter 9 Shoulder complaints regarding imaging of the shoulder,

page 207-208 recommends imaging for red flag symptoms, physiologic evidence of tissue insult or neurovascular dysfunction or failure to progress in a strengthening program. In addition imaging such as magnetic resonance imaging (MRI) would be appropriate for clarification of anatomy prior to an invasive procedure. None of the criteria has been satisfied based upon the records reviewed from 8/13/14. Therefore the request for MRI of the shoulder is not medically necessary and appropriate.

Physical Therapy Assessment and Treatment x12, Right Wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Work Loss Data Institute, LLC; Corpus Christi , TX; Section: Shoulder (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 18-22.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS)/Post-Surgical Treatment Guideline, Hand pages 21-22 recommends upwards of 24 visits of therapy postoperatively. In this case there is insufficient evidence of the type of surgery that occurred in the wrist from the exam note of 8/13/14. In addition there is insufficient evidence of the number of visits or the response to those visits. Therefore the request is not medically necessary and appropriate.