

Case Number:	CM15-0129437		
Date Assigned:	07/16/2015	Date of Injury:	05/01/2014
Decision Date:	08/14/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/03/2015

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: Preventive Medicine, Occupational Medicine

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 56 year old female who sustained a work related injury May 1, 2014. According to a primary treating physician's progress report, dated June 16, 2015, the injured worker presented May 18, 2015, with complaints of constant cervical pain, constant left shoulder pain with radiation down left arm, and intermittent bilateral wrist and hand pain. Range of motion of the cervical spine was near normal with pain and spasm present. There was positive cervical spine compression and radiating pain to the left shoulder with palpated tenderness. Neer's and Hawkins test were positive. There was tenderness to palpation of the lumbar spine with decreased range of motion with pain and spasm and hypoesthesia, L5-S1. Diagnoses are degenerative disc and facet joint disease, C2-C7(MRI July, 2014);musculoligamentous sprain, cervical spine; tendinosis of the supraspinatus and subcapularis tendons, left shoulder(MRI June 2014);mild to moderate degenerative changes acromioclavicular joint, left shoulder(MRI June 2014); mild to moderate bilateral carpal tunnel syndrome (EMG September, 2014). At issue, is the request for authorization for cortisone injection, left shoulder and physical therapy 2 x 3, left shoulder hands and wrists.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Cortisone Injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints Page(s): 48, 204, 211.

Decision rationale: Per the MTUS Guidelines, injections of corticosteroids or local anesthetics or both should be reserved for patients who do not improve with more conservative therapies. Steroids can weaken tissues and predispose to re-injury. Local anesthetics can mask symptoms and inhibit long-term solutions to the patient's problem. If shoulder pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and non-steroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. Conservative care for impingement syndrome, including cortisone injections, can be carried out for at least three to six months before considering surgery. In this case, the injured worker continues to complain of significant left shoulder pain despite an extended trial with a strengthening program and oral NSAIDs. The request for left shoulder cortisone Injection is determined to be medically necessary.

Physical therapy 2x3 (left shoulder/hands/wrists): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 98, 99.

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified, receive 9-10 visits over 8 weeks. In this case, the injured worker has had previous approved sessions of physical therapy for the shoulder/hands/wrist). The available documentation does not state how many visits were authorized or how many were actually used. The efficacy of the visits is not documented. Given that the injured worker has had previous physical therapy, she should be able to continue with a self-directed home exercise program. The request for physical therapy 2x3 (left shoulder/hands/wrists) is determined to not be medically necessary.