MAXIMUS Federal Services

Case Number:	CM13-0043036		
Date Assigned:	12/27/2013	Date of Injury:	05/12/2012
Decision Date:	05/23/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/31/2013

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 and Utah. 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 injured worker is a 30-year-old female who reported an injury on 05/12/2012 after lifting a heavy object that reportedly caused injury to her right shoulder. The injured worker's treatment history included right shoulder decompression in 11/2012, post-operative physical therapy, 1 post-operative corticosteroid injection, and various medications. The injured worker was evaluated on 09/23/2013. It was documented that the right shoulder had persistent pain rated at 5/10. Physical findings included mild tenderness at the supraspinatus, greater tuberosity, and biceps tendon with moderate tenderness to palpation over the acromioclavicular joint. The injured worker had positive subacromial crepitus and positive impingement sign. The injured worker's diagnoses included right shoulder subacromial bursitis and right shoulder synovitis. The injured worker's treatment plan included a right shoulder fluoroscopically-guided intra-articular corticosteroid injection and subacromial injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

SUBACROMIAL CORTISONE INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

Decision rationale: The requested subacromial corticosteroid injection is not medically necessary or appropriate. American College of Occupational and Environmental Medicine does recommend up to 1 to 2 injections to assist in pain control of the shoulder joint. However, the clinical documentation submitted for review does indicate that the injured worker has had a postsurgical corticosteroid injection. The results of that injection were not provided. There was no documentation of increased functional benefit or pain relief to support the need for an additional injection. As such, the requested subacromial corticosteroid injection is not medically necessary or appropriate.

RIGHT SHOULDER FLUOROSCOPY GUIDED INTRAARTICULAR CORTISONE INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

Decision rationale: The requested subacromial corticosteroid injection is not medically necessary or appropriate. American College of Occupational and Environmental Medicine does recommend up to 1 to 2 injections to assist in pain control of the shoulder joint. However, the clinical documentation submitted for review does indicate that the injured worker has had a postsurgical corticosteroid injection. The results of that injection were not provided. There was no documentation of increased functional benefit or pain relief to support the need for an additional injection. California Medical Treatment Utilization Schedule does not address the need for fluoroscopically-guided intra-articular corticosteroid injections. Official Disability Guidelines do not support the routine use of image-guided corticosteroid injections. There is no documentation to support the need for an image-guided corticosteroid injection over physical landmark-guided injection. As such, the requested right shoulder fluoroscopy-guided intra-articular corticosteroid injection is not medically necessary or appropriate.