

Case Number:	CM13-0046498		
Date Assigned:	12/27/2013	Date of Injury:	08/18/2010
Decision Date:	05/16/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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 Physician 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 59-year-old female who reported an injury on 08/18/2012 following a motor vehicle accident. Current diagnoses include bilateral shoulder contusion, bilateral shoulder subacromial bursitis, bilateral shoulder impingement, right shoulder partial rotator cuff tear, right shoulder AC joint degenerative joint disease, bilateral hip trochanteric bursitis, bilateral hip arthralgia, bilateral hip degenerative joint disease, left knee anterior horn lateral meniscus tear, left knee chondromalacia patella, posterior mid labral tear in the left shoulder, right knee chondromalacia patella and left knee degenerative joint disease. The injured worker was evaluated on 09/05/2013. The injured worker reported persistent pain in the bilateral shoulders, bilateral hips and left knee. Physical examination of the right shoulder revealed limited range of motion, positive subacromial bursitis, positive impingement testing, positive O'Brien's testing and 5/5 strength. Treatment recommendations at that time included a corticosteroid injection in the right shoulder subacromial space.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) CORTICOSTEROID INJECTION IN THE RIGHT SHOULDER SUBACROMIAL SPACE FOR THERAPEUTIC PURPOSES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER CHAPTER, STEROID INJECTION.

Decision rationale: The California MTUS/ACOEM Practice Guidelines indicate that invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy for 2 to 3 weeks. The Official Disability Guidelines indicate that steroid injections are indicated for a diagnosis of adhesive capsulitis, impingement syndrome or rotator cuff problems. There should be documentation of an interference with functional activities secondary to pain and a failure of conservative treatment, including physical therapy and exercise, NSAIDs and acetaminophen for at least 3 months. According to the documentation submitted, the injured worker's physical examination does reveal positive impingement testing. However, there is no documentation of an exhaustion of conservative treatment prior to the request for a corticosteroid injection. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.