

Case Number:	CM13-0051458		
Date Assigned:	12/27/2013	Date of Injury:	09/17/2012
Decision Date:	06/02/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	11/14/2013

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 Anesthesiology, has a subspecialty in Pain Management 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 an employee of [REDACTED] and has submitted a claim for right shoulder, right knee, and low back pain with an industrial injury date of September 17, 2012. Treatment to date has included physical therapy, chiropractic care, home exercise program, TENS unit, and medications, including APAP/hydrocodone 325/10mg 1 po q6hr (since October 2012) but at present takes Norco 10/325mg as needed (but takes 7-8 per week). Medical records from 2012 through 2013 were reviewed, which showed that the patient complained of right shoulder, right knee, and low back pain, rated 4/10 with medications. The patient reported less pain and better activities of daily living with medications. On physical examination, the right shoulder revealed positive impingement test with limited range of motion. Examination of the right knee showed 4/5 motor strength with limited range of motion. The lumbar spine showed right muscle spasm with positive Gaenslen's and sacroiliac tests but a negative straight leg-raising test. There was also slight tenderness over the left sacroiliac joint. Achilles reflexes were trace bilaterally. An MRI of the right shoulder dated 1/15/13 revealed moderate grade partial thickness intrasubstance tear with associated bursal component; diffuse degenerative cystic change with moderate to advanced chondromalacia, upper half of glenoid fossa; mild subacromial/subdeltoid bursitis; and mild AC degenerative change without significant stenosis of supraspinatus outlet. Utilization review from October 9, 2013 denied the request for 1 right shoulder subacromial injection under ultrasound guidance because of lack of guideline support; and modified the request for 1 prescription of Norco 2.5/325mg #60 to 1 prescription of Norco 2.5/325 #21 between 9/30/13 and 12/7/2013 because opioids are not recommended for long-term use without evidence of functional improvement or pain reduction. Another utilization review from November 20, 2013 certified the for 1 right shoulder subacromial injection between 11/18/2013 and 1/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

A RIGHT SHOULDER SUBACROMIAL INJECTION UNDER ULTRASONIC

GUIDANCE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Steroid injections.

Decision rationale: CA MTUS does not specifically address shoulder steroid injections; however, the Official Disability Guidelines state that for rotator cuff disease, corticosteroid injections may be superior to physical therapy interventions for short-term results, and a maximum of three are recommended. If pain with elevation is significantly limiting activities, a subacromial injection may be indicated after conservative therapy for two to three weeks but evidence is not yet overwhelming. In this case, a utilization review from November 20, 2013 certified the request for 1 right shoulder subacromial injection between 11/18/2013 and 1/17/2014; however, the medical records did not indicate whether the patient was able to undergo this procedure and whether functional improvement was achieved with it. There was also no discussion regarding the indication for a repeat shoulder injection. Although a shoulder injection may be appropriate, there is lacking information regarding the previously approved shoulder injection. Therefore, the request for a Right Shoulder Subacromial Injection under ultrasonic guidance is not medically necessary.

NORCO 2.5/325MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

Decision rationale: According to pages 79-81 of the Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless prescribed at the lowest possible dose and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, although pain relief and improved activities of daily living were reported with medications, there was no discussion regarding non-opiate means of pain control or endpoints of treatment. The records also do not clearly reflect a lack of adverse side effects or aberrant behavior. Although opiates may be appropriate, additional information would be necessary for continued opioid use. Therefore, the request for Norco 2.5/325mg #60 is not medically necessary.

