

<b>Case Number:</b>	CM13-0057790		
<b>Date Assigned:</b>	01/10/2014	<b>Date of Injury:</b>	04/04/2011
<b>Decision Date:</b>	05/08/2014	<b>UR Denial Date:</b>	11/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 a 61 year old male who was injured on 04/04/2011. The mechanism of injury is unknown. Prior treatment history has included that the patient underwent right shoulder open rotator cuff repair 01/04/2013 and right shoulder arthroscopy on 10/20/2011. Diagnostic studies reviewed include electrodiagnostic study dated 06/24/2013 revealing mild carpal tunnel syndrome affecting sensory components. Moderate left carpal tunnel syndrome affecting sensory and motor component. PR-2 dated 10/28/2013 documented the patient notes no improvement in the right shoulder since the last visit. He complained of range of motion. Locates pain to the posterior aspect of the shoulder radiating to his neck. He also continues with numbness/tingling in bilateral wrists/hands. Objective findings on exam include examination of the right shoulder with well-healed incisions. There is moderate pain with range of motion. Flexion 130 degrees, abduction 100 degrees, external rotation 70 degrees and internal rotation 10 degrees. Negative supraspinatus test. Negative cross body test. New Diagnosis: Shoulder pain, arthroscopy shoulder surgery debridement limited. Treatment: At this time we request authorization for US guided cortisone injection into the right shoulder SAB and physical medicine x 12 sessions. He will return for injection following approval.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 sessions of physical therapy:** 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 Page(s): 98-99.

**Decision rationale:** The patient underwent right shoulder open rotator cuff repair on 01/04/2013. The medical records do not document the patient's postoperative course of care. It is not documented whether the patient benefited from prior physical therapy and when he last attended. There is no mention of the patient following an independent home exercise program. There is no indication that the patient has presented with a new or recent injury of the right shoulder. Given these factors, the medical necessity for the request of physical therapy has not been established at this time. Therefore the request is non-certified.

**Ultrasound guided cortisone injection to the right shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER, STEROID INJECTIONS

**Decision rationale:** The according to the guidelines, criteria for steroid injections includes documentation that symptoms have not been controlled adequately with recommended conservative treatments such as physical therapy and exercise, NSAIDs or acetaminophen, for a duration of at least three months. However the medical records provide no mention of the course of conservative treatment rendered to the patient. It is not established that his symptoms have failed to benefit from standard conservative interventions. In addition, steroid injections are generally performed without ultrasound guidance, the guidelines state that there is no current evidence that imaging guidance for shoulder injections improves patient-relevant outcomes. Consequently, the criteria necessary to establish the medical necessity for steroid injection has not been met. In accordance with the guidelines, the medical necessity for steroid injection is not been established. Therefore the request is non-certified.