

<b>Case Number:</b>	CM14-0000460		
<b>Date Assigned:</b>	01/17/2014	<b>Date of Injury:</b>	12/27/2007
<b>Decision Date:</b>	06/11/2014	<b>UR Denial Date:</b>	12/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2014

### 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, and is licensed to practice in Illinois. 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 61-year-old who reported an injury on December 27, 2007. The mechanism of injury was not provided. Per the December 19, 2013 clinical note, the injured worker reported low back pain, left leg pain, and right sided neck and shoulder pain. Objective findings included paravertebral and paraspinal tenderness to palpation, a positive straight leg raise on the left at 30 degrees, and weakness and tingling in both legs. Severe tenderness was noted over the right shoulder acromioclavicular joint with severe limitation of movement and rotation. The injured worker's diagnoses included cervical pain, shoulder pain, cervical radiculopathy, low back pain, sciatica, and lumbar disk herniation. Treatment to date included medications and cervical and lumbar epidural steroid injections. The request for authorization form for a right shoulder injection and lumbar epidural steroid injection was not present in the medical record.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT SHOULDER INJECTION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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, Steroid injections.

**Decision rationale:** The Shoulder Complaints Chapter of the ACOEM Practice Guidelines states invasive techniques for the shoulder 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 (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The Official Disability Guidelines further state, there should be a diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder to warrant steroid injections. The medical records provided do not indicate the injured worker has a diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems. The physical exam noted severe tenderness and limitation of movement. There is a lack of documentation regarding failure of conservative treatment for the shoulder. The medical necessity for a right shoulder injection was not established. The request for a right shoulder injection is not medically necessary or appropriate.

**LUMBAR EPIDURAL INJECTION (LEVEL NOT SPECIFIED):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESI), Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIS) Page(s): 46.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state the following criteria for the use of epidural steroid injections: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; pain must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants); injections should be performed using fluoroscopy (live x-ray) for guidance; and repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. There were no imaging studies present in the medical records to corroborate findings of radiculopathy. There is also no indication the injured worker has failed conservative treatment. The medical records provided indicate the injured worker received a lumbar epidural steroid injection at L4-5 on 10/30/2013.