MAXIMUS Federal Services

Case Number:	CM14-0102830		
Date Assigned:	07/30/2014	Date of Injury:	10/12/2012
Decision Date:	08/29/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	07/03/2014

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, 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:

This is a patient with a date of injury of October 12, 2012. A utilization review determination dated June 3, 2014 recommends non-certification of ultrasound guided steroid injection for the right shoulder. Non-certification was recommended since Official Disability Guidelines recommend performing shoulder injections without fluoroscopic or ultrasound guidance. A chiropractic report dated May 27, 2014 recommends ongoing chiropractic care 3 times a week for 4 weeks for the patient's right shoulder diagnosis. A progress report dated February 6, 2014 identifies subjective complaints of right shoulder pain with a diagnosis of partial tear of the rotator cuff with impingement. The patient had only slight and temporary relief with physical therapy and shock treatment. He still has difficulty lifting his arm above the shoulder level and he has painful use and secondary weakness. Physical examination findings identified limited range of motion in the right shoulder with limited internal and external rotation. Diagnostic studies reportedly indicate subacromial tendinopathy, impingement, and partial tear of the rotator cuff. Diagnoses include low grade partial thickness tear of the posterior supraspinatus and anterior infraspinatus tendons, partial thickness tear of the subscapularis tendon, mild fraying and possible tearing of the posterior portion of the labrum, and moderate to severe acromioclavicular joint osteoarthritis. The treatment plan states that the patient did have one injection by the treating physician which did not help, after which time the patient was advised that he needed surgery. The note indicates that the treating physician recommended a trial of subacromial cortisone injection which he refused. The patient decided to proceed with arthroscopy of the right shoulder with decompression and repair of the rotator cuff as needed. A progress report dated February 21, 2014 includes a treatment plan recommending right shoulder arthroscopy to be approved. A progress note dated January 9, 2014 includes a history of present illness which states that the patient had failed to respond to conservative treatment, and surgery was

recommended. The treatment plan recommends right shoulder arthroscopic repair of the rotator cuff.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound-Guided Steroid Injection for the Rt Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder page 204 Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative treatment for 2 or 3 weeks. They go on to recommend the total number of injections should be limited to 3 per episode, allowing for assessment of benefits between injections. Official Disability Guidelines recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, when pain interferes with functional activities. Guidelines state that a 2nd injection is not recommended if the 1st has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, it does not appear the patient had any significant analgesic efficacy or objective functional improvement from the previous shoulder injection. Additionally, it appears the patient has declined to repeat a shoulder injection. Finally, guidelines do not support the use of imaging guidance for shoulder injections. As such, the currently requested repeat right shoulder injection with ultrasound is not medically necessary.