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| Case Number: | CM14-0013198 | | |
| Date Assigned: | 02/24/2014 | Date of Injury: | 06/29/1998 |
| Decision Date: | 07/24/2014 | UR Denial Date: | 01/28/2014 |
| Priority: | Standard | Application Received: | 02/03/2014 |

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 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:

This patient is a 56-year-old male who has submitted a claim for Closed Dislocation of Acromioclavicular Joint; Osteoarthritis, Localized, Primary, Involving Lower Leg; Mechanical Complication of Internal Orthopedic Device, Implant, and Graft; Causalgia of Lower Limb; Lumbago; and Morbid Obesity, associated with an industrial injury dated June 29, 1998. Medical records from 2012 through 2014 were reviewed, which showed that the patient complained of chronic back, knee, and shoulder pain, rated 10/10. On physical examination, musculoskeletal examination revealed normal findings. Gait was antalgic on the right. Lumbar spine postural position was hypolordotic in appearance. The patient used a cane for ambulation. Impingement sign for supraspinatus or biceps tendon injury was positive on the right. There was decreased sensation on the right foot. Motor strength was 5-/5. Treatment to date has included medications and a home exercise program. Utilization review from January 28, 2014 denied the request for right shoulder injection because of an absence of response to the request for additional information.

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: 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 Chapter, Steroid injections.

Decision rationale: The California MTUS does not specifically address shoulder injections. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that criteria for steroid injections include: (1) diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems; (2) not controlled adequately by recommended conservative treatments after at least 3 months; (3) pain interferes with functional activities; and (4) intended for short-term control of symptoms to resume conservative management. In this case, physical examination findings revealed a positive impingement sign for the right shoulder. However, there was no discussion regarding failure of recommended conservative treatment options. There was also no indication that shoulder pain has interfered with functional activities. A clear rationale for the requested procedure was not provided. Therefore, the request for right shoulder injection is not medically necessary.