

Case Number:	CM14-0017949		
Date Assigned:	04/16/2014	Date of Injury:	05/19/2009
Decision Date:	06/30/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/12/2014

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 & Rehabilitation, 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 injured worker is a 62-year-old male who reported an injury on 05/19/2009. The mechanism of injury involved a fall. The current diagnoses include capsulitis/peri-arthritis/tendinitis, shoulder impingement syndrome, shoulder/upper arm sprain/strain, herniated disc, and lumbar spine spondylosis. The injured worker was evaluated on 11/18/2013. Previous conservative treatment includes 3 epidural steroid injections into the lower back and physical therapy. Physical examination revealed tenderness to palpation over the left parascapular muscle, limited left shoulder range of motion, positive impingement testing, diminished strength, two plus deep tendon reflexes in bilateral upper extremities, intact sensation, tenderness over the thoracic and lumbar paraspinal muscles, limited lumbar range of motion, spasm and guarding, and diminished strength in the bilateral lower extremities. The injured worker was currently participating in acupuncture and physical therapy. The treatment recommendations at that time included continuation of current medication, a follow up with a pain management consultation, and a left shoulder injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

CAUDAL INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: The California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patients should also prove initially unresponsive to conservative treatment. There was no specific body part listed in the current request. Therefore, the request is non-certified.

CERVICAL INJECTION (UNKNOWN WHAT TYPE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: The California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patients should also prove initially unresponsive to conservative treatment. There was no specific type of injection listed in the request. Therefore, the request is non-certified.

LEFT SHOULDER INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Steroid injection.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of a local anesthetic and a corticosteroid preparation may be indicated after conservative therapy for 2 to 3 weeks. There is no mention of an exhaustion of conservative treatment for the left shoulder. Additionally, the specific type of injection was not listed in the current request. Therefore, the request is non-certified.