

Case Number:	CM14-0118299		
Date Assigned:	08/06/2014	Date of Injury:	12/16/2007
Decision Date:	09/17/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/25/2014

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 Anesthesiologist and Pain Medicine and is licensed to practice in Florida. 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 female who reported an injury on 12/16/2007. The mechanism of injury was not provided. On 01/23/2014, the injured worker presented with cervicothoracic pain, bilateral shoulder pain, and bilateral knee pain and lumbosacral radicular symptoms. An MRI performed on 04/01/2013 demonstrated right shoulder status post acromioplasty rotator cuff repair and bicep tenodesis, severe tendinosis and partial thickness tearing of the supraspinatus tendon, infraspinatus and subscapularis tendinosis and small subacromial deltoid bursal effusion. Physical examination was not performed at the date of this clinical note. The diagnoses were adhesive capsulitis at the bilateral shoulders, lumbar disc myelopathy, lumbar degenerative disc disease and lumbar spondylosis. Prior therapy included medications, psychiatric therapy, surgery, and injections. The provider recommended a left shoulder cortisone injection, the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Cortisone Injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Shoulder; Shoulder Injections.

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

Decision rationale: The request for the left shoulder cortisone injection is non-certified. The California MTUS/ACOEM state invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a cortisone preparation may be indicated after conservative therapy from 2 to 3 weeks. Evidence supporting such an approach is not overwhelming, and the number of injections should be limited to 3 per episode for assessment and benefit between injections. The provider's request does not indicate the amount of injections in the request as submitted. Additionally, there is lack of documentation of functional deficits pertaining to the left shoulder. There is lack of documentation of failure to respond to conservative care. As such, the request Left Shoulder Cortisone Injection is not medically necessary.