

<b>Case Number:</b>	CM14-0169652		
<b>Date Assigned:</b>	10/17/2014	<b>Date of Injury:</b>	07/31/2013
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	09/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2014

### 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 Interventional Spine 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 patient is a 70 years old female with an injury date on 07/31/2013. Based on the 09/04/2014 progress report provided by [REDACTED], the diagnoses are: 1. Status post left shoulder arthroscopy. 2. Right shoulder rotator cuff tendinitis / bursitis secondary to overuse. 3. Right knee sprain / strain 4. Right knee chondromalacia. According to this report, the patient complains of "constant pain in the right shoulder and especial with activity and any kind of movement." Physical exam reveals tenderness to palpation about the trapezius musculature. There is restricted range of motion due to pain. Impingement test and lift off subscapularis are positive on the right. Supraspinatus weakness is positive bilaterally. There were no other significant findings noted on this report. The utilization review denied the request on 09/15/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 07/10/2014 to 09/04/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Cortisone Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter under steroid injection

**Decision rationale:** According to the 09/04/2014 report by [REDACTED] this patient presents with "constant pain in the right shoulder and especial with activity and any kind of movement." The treater is requesting decision for right shoulder cortisone injection. The utilization review denial letter states "The patient received a corticosteroid injection for the right shoulder on 05/07/2014 with no improvement reported." It would appear that the patient had a prior shoulder injection but the treater does not discuss it. Regarding repeat injection, ODG guidelines state "A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response." In this case, there were no documentations of improvement or complete resolution of symptom from prior injection. MTUS page 8 requires that the treater provide monitoring of the patient's progress and make appropriate recommendations. Recommendation is for denial.