

<b>Case Number:</b>	CM14-0025550		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	01/02/2013
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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, and is licensed to practice in Nevada. 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 male was reportedly injured on 1/2/2013. The mechanism of injury is not listed. The injured worker underwent arthroscopic right shoulder surgery on 6/28/2013. The most recent progress note dated 1/23/2014, indicates that there are ongoing complaints of right shoulder pain, popping, limited motion and weakness as well as left shoulder pain due to over-compensation. Physical examination demonstrated healed surgical incision without erythema; shoulder range of motion was restricted: FE 180 passive, active to 170, ER 70 active and passive, IR 60 degrees. No diagnostic imaging studies available. Diagnosis: right shoulder pain status post arthroscopic shoulder surgery for a rotator cuff tear. Previous treatment includes postoperative physical therapy and home exercises. A request had been made for one cortisone injection to right shoulder and was not certified in the utilization review on 2/17/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CORTISONE INJECTION X 1 TO RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder (Acute and Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Integrated Treatment/Disability Duration Guidelines; Shoulder (Acute & Chronic) - Steroid Injections.

**Decision rationale:** California Medical Treatment Utilization Schedule fails to address cortisone injections of the shoulder. Official Disability Guidelines support steroid injections for specific diagnosis: adhesive capsulitis, impingement syndrome and rotator cuff problems; except for post-traumatic impingement of the shoulder. One injection is supported after failure of 3 months of conservative treatment; pain interferes with functional activities, and is intended for short-term control of symptoms to resume conservative medical management. Review of the available medical records, fails to document conservative treatment to include a trial of anti-inflammatories and/or physical therapy. As such, the request is not considered medically necessary.