

Case Number:	CM14-0035293		
Date Assigned:	06/23/2014	Date of Injury:	12/07/1995
Decision Date:	07/30/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/21/2014

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, 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 is a male patient with the date of injury of December 7, 1995. A Utilization Review was performed on February 27, 2014 and recommended non-certification of cortisone injection left shoulder via ultrasound. An Evaluation dated January 21, 2014 identifies History of Present Illness of pain in the left shoulder, pain with any motion. Physical Examination identifies shoulder ROM is restricted. Rotator cuff strength testing shows 4/5 abduction, external rotation, and internal rotation on the left. Positive Neer and Hawkins. Assessment identifies recurrent impingement, rotator cuff tendinitis, bursitis left shoulder. Plan identifies injection the subacromial region with ultrasound guidance. A Progress Note dated October 21, 2013 identifies the patient's left shoulder was injected.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder cortisone injection via ultrasound: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Shoulder pain/rotator cuff syndrome.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Steroid injections.

Decision rationale: Guidelines recommend shoulder injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems, following 3 months of conservative treatment. Repeat injections are not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, the patient underwent prior injection. However, there is no mention of the patient's response to this previous injection. In the absence of such documentation, the requested left shoulder cortisone injection via ultrasound is not medically necessary.