

Case Number:	CM14-0041272		
Date Assigned:	06/27/2014	Date of Injury:	06/21/2010
Decision Date:	08/26/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/07/2014

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 Anesthesiology, 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 52-year-old male patient with a 6/21/10 date of injury. The mechanism of injury was not provided. A progress report dated on 3/12/14 indicated that the patient continued to have burning pain and felt cold pain radiating to the right lower extremity. The patient also complained of cervical spine pain and shoulder pain depending on movement and right wrist numbness and tingling. Objective finding revealed decreased range of motion in the lumbar spine. Two view x-rays of right shoulder showed mild increased acromial spurring. He was diagnosed with lumbago, intervertebral disc disorder, rotator cuff, and carpal tunnel syndrome. Treatment to date: medication management, physical therapy. There is documentation of a previous 3/24/14 adverse determination, based on the fact that there was no physical examination provided that supported an intraarticular condition treatable by steroid injection. The ultrasound guidance was not certified because intraarticular injection was not certified. Urinalysis was not certified based on the fact that it was not clear how long the patient was taking opioid medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Restrospective Intra-Articular Cortisone Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Shoulder Chapter).

Decision rationale: CA MTUS does not address this issue. ODG states that for rotator cuff disease, corticosteroid injections may be superior to physical therapy interventions for short-term results, and a maximum of three are recommended. If pain with elevation is significantly limiting activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and NSAIDs) for two to three weeks, but the evidence is not yet overwhelming, and the total number of injections should be limited to no more than three. The patient presented with cervical spine pain, shoulder pain depending of movement and right wrist numbness and tingling. X-ray demonstrated right shoulder mild increased acromial spurring. However, there was no documentation supporting significant limitation of activities due to pain. In addition, the retrospective date of request for injection was not clear. Therefore, the request for Retrospective Intra-Articular Cortisone Injection was not medically necessary.

Restrospective Urinalysis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Use of Opioids; Drug Testing; Urine Testing in ongoing Opiate Management Page(s): 222-238; 43; 78.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that a urine analysis is recommended as an option to assess for the use or the presence of illegal drugs, to assess for abuse, to assess before a therapeutic trial of opioids, addiction, or poor pain control in patients under on-going opioid treatment. There was documentation supporting opioid prescription since at least 9/24/13. There was evidence of two drug urine screen test, 10/26/13 which was negative for Hydrocodone, and 11/07/13 that was positive for Hydrocodone. However, it was not identified what the retrospective date of request for urinalysis was. It is unclear why another UDS would be required. Therefore, the request for Retrospective Urinalysis was not medically necessary.

Restrospective requestfor Ultrasound Guidance Right Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter: Steroid Injections.

Decision rationale: CA MTUS does not address this issue. Glucocorticoid injection for shoulder pain has traditionally been performed guided by anatomical landmarks alone, and that is still

recommended. With the advent of readily available imaging tools such as ultrasound, image-guided injections have increasingly become more routine. While there is some evidence that the use of imaging improves accuracy, there is no current evidence that it improves patient-relevant outcomes. However, there was no medical necessity for intra-articular steroid injection, so the associated request for ultrasound cannot be substantiated. Therefore, the request for Retrospective request for Ultrasound Guidance Right Shoulder was not medically necessary.