MAXIMUS Federal Services

Case Number:	CM14-0059919		
Date Assigned:	07/09/2014	Date of Injury:	01/02/1998
Decision Date:	09/05/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	04/30/2014

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 Occupational Medicine, 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 71-year-old male who has submitted a claim for lumbar disc displacement without myelopathy associated with an industrial injury date of January 2, 1998.Medical records from March 2014 through April 2014 were reviewed, which showed that the patient complained of back pain, knee pain, shoulder pain and elbow pain. Physical examination revealed a right-sided heel strike antalgic gait and a stooped gait. Examination of the lumbar spine revealed restricted range of motion in all planes due to pain, as well as hypertonicity, spasm, tenderness, tight muscle band, and trigger point over the paravertebral muscles bilaterally. Straight leg raise test was positive on both sides. Tenderness over the sacroiliac spine was noted. Trigger point with radiating pain and twitch response was noted at the paraspinal muscles on both sides. Left shoulder exam showed atrophy of the left shoulder joint with restricted range of motion in all planes associated with pain. Tenderness over the acromioclavicular joint, glenohumeral joint and subdeltoid bursa was noted. Right knee examination showed swelling with restricted range of motion. No MRI findings were included in the records for review. Treatment to date has included steroid injections, shoulder surgery, and medications, which include OxyContin 30mg, Norco 10/325mg, Lyrica, Metanx 3-35-2, Zoloft 50mg, Lyrica 75mg, Ambien 10mg, and Colace 100mg. Utilization review from April 25, 2014 denied the request for cortisone injection for the left shoulder as an outpatient because there was no documentation of a physical examination done. There was no recent history noted and there was no documentation of any prior injections or treatments and treatment response. There was also no documentation of any diagnostic workup.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Cortisone Injection for the Left Shoulder, as an Outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

Decision rationale: CA MTUS does not specifically address corticosteroid injections. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) was used instead. ODG states that there is limited research to support the routine use of subacromial injections for pathologic processes involving the rotator cuff, but this treatment can be offered to patients. For rotator cuff disease, corticosteroid injections may be superior to physical therapy interventions for short-term results, and a maximum of three are recommended. Subacromial injections of corticosteroids are effective for improvement for rotator cuff tendinitis up to a 9-month period. ODG states that criteria for steroid injections include: (1) diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems; (2) not controlled adequately by recommended conservative treatments for at least 3 months; (3) pain interferes with functional activities; (4) intended for short-term control of symptoms to resume conservative management; (5) with several weeks of temporary partial resolution of symptoms and then worsening pain and function, a repeat steroid injection may be an option; and (6) the number of injections should be limited to three. In this case, there was no documentation of prior injections and objective and functional improvements following treatment. Moreover, the date of injury has been over 9 months, which is the period where corticosteroid injections will be most effective. Documentation of prior treatments to the shoulder and treatment response was not included in the records for review. There was no evidence that the patient had prior physical therapy, which is a necessary adjunct for steroid injection. Although there were physical examination findings indicative of shoulder pathology, MRI findings for the left shoulder, as well as the diagnosis of the shoulder pathology, were not included in the records. Guideline criteria were not met. The medical necessity cannot be established due to insufficient information. Therefore, the request for 1 Cortisone Injection for the Left Shoulder, as an Outpatient is not medically necessary.