

<b>Case Number:</b>	CM14-0064126		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	10/09/2013
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	04/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 40 year old female who was injured on 10/09/13. Per the progress note dated 01/27/14, the injured worker complains of right shoulder pain with spasm, loss of ROM and numbness. Previous treatment for this complaint is not described. This note indicates the injured worker is prescribed Norco and Flexeril. Physical examination is significant for limited ROM and pain about the right shoulder. A handwritten note is difficult to interpret but appears to state the injured worker demonstrated right shoulder impingement upon MRI. Other comments, to include the treatment plan, are illegible. A request for a right shoulder injection is received for determination on 03/26/14 and is subsequently denied by Utilization Review dated 04/03/14. The rationale cites no diagnosis or imaging studies suggestive of rotator cuff inflammation, impingement syndrome or small tears. This is an appeal request for a right shoulder injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Right shoulder injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563.

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

**Decision rationale:** The request for one right shoulder injection is not recommended as medically necessary. The type of injection to be performed is not specified by the request or within the documentation. ACOEM indicates that invasive techniques, such as injections, have limited proven value. This guideline states, "If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and non-steroidal anti-inflammatory drugs) for two to three weeks." The records do not indicate the injured worker has participated in or has failed to appropriately respond to conservative therapy such as exercise. The submitted documentation included only one clinical note which failed to provide clear evidence of a significant pathology involving the right shoulder. It is noted the injured worker demonstrates limited shoulder ROM; however, the degree of limitation is not noted. The degree of the injured worker's complaint of shoulder pain is not reported. There is no imaging studies submitted for review. Based on the clinical information provided, medical necessity of an injection to the right shoulder is not established.