

<b>Case Number:</b>	CM15-0100443		
<b>Date Assigned:</b>	06/02/2015	<b>Date of Injury:</b>	10/19/2011
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 43 year old male, who sustained an industrial injury on October 19, 2011. He reported an injury to his low back. Treatment to date has included TENS unit, medications, EMG studies, physical therapy, acupuncture and hot/cold therapy. Currently, the injured worker complains of continued neck pain, headaches, right shoulder pain and low back pain. He reports that the pain is relatively the same and he has quite a bit of muscle spasms and knots in his mid and low back. He has headaches on a regular basis and reports numbness and tingling in the left lower extremity. He reports that he is not sleeping well. Use of his TENS units help his pain. On physical examination he has tenderness to palpation over the cervical, thoracic and lumbar paraspinal muscles bilaterally and pain along the right shoulder, rotator cuff and biceps tendon. The diagnoses associated with the request include discogenic cervical condition with facet inflammation and right side radiculopathy, right shoulder impingement with bicipital tendinitis, discogenic lumbar condition with facet inflammation with bilateral radiculopathy. The treatment plan includes medications, cortisone injections, chiropractic therapy, referral to neurologist and cervical traction.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cortisone Injection in Subacromial Space, Right Shoulder:** 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 Steroid injection <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, shoulder injection is recommended: Criteria for Steroid injections: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (eg, pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management; Generally performed without fluoroscopic or ultrasound guidance; Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three. There is no recent documentation of failure of conservative therapies including medication and physical therapy. There is no documentation of adhesive capsulitis, impingement syndrome, or rotator cuff problems. Therefore the request for Cortisone Injection in Subacromial Space, Right Shoulder is not medically necessary.