

Case Number:	CM15-0107901		
Date Assigned:	06/15/2015	Date of Injury:	07/18/2014
Decision Date:	07/14/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	06/04/2015

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 41-year-old female, who sustained an industrial injury on July 18, 2014 while working as a clerk. The mechanism of injury was repetitive activities. The injured worker has been treated for neck, left shoulder and low back complaints. The diagnoses have included left shoulder impingement and cervical herniated disc. Treatment to date has included medications, radiological studies, MRI and physical therapy. Current documentation dated April 14, 2015 notes that the injured worker reported neck pain and left shoulder and arm pain. Examination of the cervical spine revealed seventy degrees of flexion and seventy degrees of extension. Left shoulder examination revealed a decreased range of motion and a positive impingement sign. The treating physician's plan of care included a request for an arthrodesis left shoulder injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthrodesis left shoulder 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 injection.

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 (e.g., 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 documentation of improvement of shoulder range of motion with current medications. Therefore, the request for Arthrodesis left shoulder injection is not medically necessary.