

<b>Case Number:</b>	CM15-0142553		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	07/22/2014
<b>Decision Date:</b>	09/08/2015	<b>UR Denial Date:</b>	07/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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: Texas, California

Certification(s)/Specialty: Family Practice

### 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 21 year old male patient, who sustained an industrial injury on July 22, 2014. He sustained the injury due to involved in a motor vehicle accident. The diagnoses include a left ear laceration, collapsed lung, lumbar sprain, non-displaced fracture of the thoracic spine, left shoulder impingement syndrome, left bicipital tendinitis, left internal knee derangement and post-traumatic headaches. Per the doctor's note dated 6/16/2015, he had complaints of back pain, left shoulder pain, left knee pain and head pain. The physical examination revealed full range of motion with pain of the left shoulder and left elbow; lumbar spine- tenderness and decreased range of motion; left knee- flexion 120 and extension -2 degree and lateral joint space tenderness. The medications list includes ibuprofen and cymbalta. Treatment included 8 physical therapy visits for the left shoulder, pain medications, steroid injections and total temporary disability. The treatment plan that was requested for authorization included a subacromial steroid injection for the left shoulder and physical therapy twice a week for 6 weeks for the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Subacromial steroid injection for left shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Shoulder (updated 08/06/15), Steroid injections.

**Decision rationale:** Subacromial steroid injection for left shoulder. As per the ACOEM guidelines, "Invasive techniques have limited proven value. 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 evidence supporting such an approach is not overwhelming." Per the cited guidelines, cortisone injection is given after trial of conservative therapy. In addition per the ODG, "Steroid injections compared to physical therapy seem to have better initial but worse long-term outcomes. There is limited research to support the routine use of subacromial injections for pathologic processes involving the rotator cuff." Response to previous conservative therapy including physical therapy visits and pharmacotherapy is not specified in the records provided. Previous conservative therapy notes are not specified in the records provided. The medical necessity of Subacromial steroid injection for left shoulder is not fully established for this patient. The request is not medically necessary.

**Physical therapy 2x6 weeks for left shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy, page 98.

**Decision rationale:** Physical therapy 2x6 weeks for left shoulder. The cited guidelines recommend up to 9-10 physical therapy visits for this diagnosis. Per the records provided, patient has had 8 physical therapy visits for this injury. The requested additional visits in addition to the previously rendered physical therapy sessions are more than recommended by the cited criteria. There is no evidence of significant progressive functional improvement from the previous physical therapy visits that is documented in the records provided. Previous physical therapy notes are not specified in the records provided. Per the cited guidelines, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of Physical therapy 2x6 weeks for left shoulder is not established for this patient at this time. The request is not medically necessary.