

Case Number:	CM15-0205119		
Date Assigned:	10/22/2015	Date of Injury:	03/02/2015
Decision Date:	12/10/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	10/19/2015

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 42 year old female patient who sustained an industrial injury on 03-02-2015. The diagnosis includes left shoulder rotator cuff syndrome. According to the treating physician's progress report on 09-16-2015, the patient returned to proceed with cortisone injection followed by physical therapy. The left shoulder was injected by the provider. There were no objective findings of the left shoulder documented. According to the treating physician's progress report on 08-07-2015, the patient expressed pain from the base of the neck to the elbow associated with some tingling around the shoulder blade with motion. Examination demonstrated full range of motion with negative atrophy; non-tender acromioclavicular joint, negative lift-off, belly press and empty can tests. Current medication was noted as Ibuprofen. She had recent left shoulder magnetic resonance imaging (MRI) dated 6/1/15 which revealed some tendinopathy of the supraspinatus and some bursitis. Prior treatments have included diagnostic testing, ice, physical therapy (24 sessions completed according to the progress noted on 08-07-2015) and medications. Per the UR dated 7/1/15, the request of possible cortisone injection was approved. Treatment plan consists of home exercise program and the current retrospective request by the provider on 09-28-2015 for a Marcaine-Cortisone injection of the left shoulder region (DOS: 09-16-2015). On 10-05-2015 the Utilization Review determined the request for Marcaine-Cortisone injection was not medically necessary since a prior request for cortisone injections was approved by the Utilization Review on 07-01-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Marcaine/Cortisone injections: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Steroid injections.

Decision rationale: According to 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. According to the cited guidelines a cortisone injection is given after a trial of conservative therapy. In addition according to the ODG, criteria for steroid injections include: 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; and when 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 and 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. Per the records provided the patient has diagnosis of left shoulder rotator cuff syndrome. The patient has tried conservative therapy including medications and physical therapy visits. Therefore a steroid injection would be medically appropriate for this patient. However, per the UR dated 7/1/15, the request of possible cortisone injection was approved. The outcome or response of this injection was not specified in the records provided. The rationale for a second injection without documentation of the response to previously approved injection is not specified in the records provided. The medical necessity of Marcaine/Cortisone injections is not medically necessary for this patient at this time.