MAXIMUS Federal Services

Case Number:	CM15-0021476		
Date Assigned:	02/11/2015	Date of Injury:	06/28/2005
Decision Date:	04/07/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	02/04/2015

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: California, District of Columbia, Maryland
Certification(s)/Specialty: Anesthesiology, Pain Management

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 61 year old female, who sustained an industrial injury on June 28, 2005. The diagnoses have included cervical radiculitis and lumbar radiculitis. Treatment to date has included medication, physical therapy for the cervical spine, and self-guided weight loss. Currently, the injured worker complains of neck pain with radiation of pain to the arms. The injured worker reports low back pain with radiation of pain to the bilateral legs with associated numbness and tingling. An epidural steroid injection for the lumbar spine was scheduled. The injured worker complains of right shoulder and arm pain during range of motion and is planning on injection. On examination, she has cervical spine decreased range of motion with mild paravertebral tenderness and lumbar spine decreased range of motion with positive paravertebral tenderness. She has a positive straight leg raise and has marked antalgic gait. On January 9, 2015 Utilization Review non-certified a request for one right subacromial injection and one re-evaluation in six weeks noting that there was no indication of conservative care in the form of physical therapy every being attempted or failed for the right shoulder and noting that the injured worker's complaints did not require complicated decision-making and the risk for complications or morbidity

were not high requiring a re-evaluation. The Official Disability Guidelines and the ACOEM were cited. On February 4, 2015, the injured worker submitted an application for IMR for review of one right subacromial injection and one re-evaluation in six weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right subacrominal injection: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, Steroid Injections.

Decision rationale: Per the ODG guidelines: 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. The documentation submitted for review did not indicate that conservative care with physical therapy and NSAIDs was trialed and failed for at least 3 months. As the criteria is not met, medical necessity cannot be affirmed.

1 Re-evaluation with 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, Steroid Injections.

Decision rationale: Per the ODG guidelines: 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. As the requested injection was not medically necessary, re-evaluation is not medically necessary.