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| Case Number: | CM15-0022702 | | |
| Date Assigned: | 02/12/2015 | Date of Injury: | 03/08/2014 |
| Decision Date: | 04/08/2015 | UR Denial Date: | 01/09/2015 |
| Priority: | Standard | Application Received: | 02/06/2015 |

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 45-year-old male who reported an injury on 03/08/2014 due to an unspecified mechanism of injury. On 12/31/2014 he presented for a follow-up. He stated that he had marked improvement following his injection, but that with the cold weather, he had a flare up of his pain. He rated his pain level at the visit to be a 10/10 in the left shoulder. Physical examination showed negative provocative testing. Resisted abduction strength was a 4/5 and range of motion was noted to be normal with the exception of forward flexion, which was 160 degrees. He was diagnosed with left shoulder rotator cuff tendonitis and left shoulder status post arthroscopy with subacromial decompression and AC joint resection. The treatment plan was for an ultrasound guided steroid injection of the left shoulder. The rationale for treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound Guided Steroid Injection of the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines - Shoulder, Steroid Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 201-205.

Decision rationale: The California/ACOEM Guidelines state that invasive techniques have limited proven value, but that if pain with elevation significantly limits activities, a subacromial injection of local anesthetic and corticosteroid preparation may be indicated after failure of conservative therapy. The documentation provided does state that the injured worker had undergone an injection previously and that he reported a relief of his pain. However, there is a lack of documentation showing that the injured worker has failed all recommended forms of conservative therapy to support the request for an additional injection. Also, his response to the injection in terms of a quantitative decrease in pain and an objective improvement in function to the previous injection was not clearly documented. Therefore, the request is not supported. As such, the request is not medically necessary.