

Case Number:	CM15-0024797		
Date Assigned:	02/17/2015	Date of Injury:	08/31/1987
Decision Date:	03/31/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	02/09/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 53 year old female, who sustained an industrial injury on 8/31/1987. On 2/9/15, the injured worker submitted an application for IMR for review of Home Care 5x6 Weeks, and Right Subacromial Injection under Ultrasound Guidance. The treating provider has reported the injured worker complained of low back pain and increased right shoulder pain. The diagnoses have included cervical bilateral upper extremity radiculopathy, bilateral shoulder sprain, bilateral elbow medial and lateral epicondylitis, bilateral forearm/wrist tenosynovitis, carpal tunnel syndrome. Treatment to date has included status post spinal cord stimulator removal (6/20/14), status post release left deQuervain's, MRI lumbar (7/12/14. Right shoulder injections. On 1/19/15 Utilization Review non-certified Home Care 5x6 Weeks, and Right Subacromial Injection under Ultrasound Guidance. The ODG Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Care 5x6 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51. Decision based on Non-MTUS Citation Pain, Home Health Services

Decision rationale: According to MTUS and ODG Home Health Services section, Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Given the medical records provided, employee does not appear to be homebound. The treating physician does not detail what specific home services the patient should have. Additionally, documentation provided does not support the use of home health services as medical treatment, as defined in MTUS. The treating physician documents that the home health services are utilized as a preventative measure for patient's pain. As such, the current request for Home Care 5x6 Weeks is not medically necessary.

Right Subacromial Injection Under Ultrasound Guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 19th Edition, Shoulder Chapter, Steroid Injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-252. Decision based on Non-MTUS Citation Shoulder, Injections

Decision rationale: ACOEM states two or three sub- acromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears (C, D). ACOEM C recommendation Limited research-based evidence (at least one adequate scientific study of patients with shoulder disorders). ACOEM D recommendation Panel interpretation of information not meeting inclusion criteria for research-based evidence. ODG 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. Guidelines recommend against the use of

ultrasound guidance for these types of injections. In addition, the treating physician has not provided a medical rationale to meet the above guidelines at this time. As such, the request for Right Subacromial Injection Under Ultrasound Guidance is not medically necessary.