

<b>Case Number:</b>	CM15-0210268		
<b>Date Assigned:</b>	10/29/2015	<b>Date of Injury:</b>	05/12/1999
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	10/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/26/2015

### 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: North Carolina

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:

The injured worker is a 71 year old female who sustained an industrial injury on 5-12-99. A review of the medical records indicates she is undergoing treatment for shoulder pain, bilateral shoulder impingement syndrome, and bilateral wrist occasional pain. Medical records (9-15-15) indicate complaints of pain in bilateral shoulders. She also complains of cervical spine pain and limited range of motion. She reports that the pain radiates, at times, to the bilateral wrists. She reports awaking at night with shoulder pain. She also reports aching, soreness, decreased range of motion, and an inability to reach overhead. She reports that her pain has "gotten worse". The physical exam reveals tenderness at the anterior acromial border, lateral acromial border, and greater tuberosity of the right shoulder. Range of motion is noted to be diminished. Strength is noted to be "4 out of 5" in forward flexion and abduction. Pain is noted with testing. Neer and Hawkins-Kennedy tests are positive. The left shoulder exam mirrors the right exam. Diagnostic studies have included x-rays of bilateral shoulders. Treatment has included medications. The treatment plan is for bilateral shoulder subacromial injections. The utilization review (10-9-15) includes a request for authorization of subacromial injections with ultrasound guidance to bilateral shoulders. The request was modified to certify the left shoulder injection only.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Subacromial injection, right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute & Chronic) - Steroid injection.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

**Decision rationale:** The ACOEM chapter on shoulder complaints states: 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. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. There is no evidence in the medical records that pain with elevation is significantly limiting activities. There are also no physical exam findings of unusual anatomy that would require ultrasound or fluoroscopic guidance for this routine injection. Therefore the request is not medically necessary.

**Ultrasound guidance [for Subacromial injection, right shoulder]:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute & Chronic) - Steroid injection.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

**Decision rationale:** The ACOEM chapter on shoulder complaints states: 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. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. There is no evidence in the medical records that pain with elevation is significantly limiting activities. There are also no physical exam findings of unusual anatomy that would require ultrasound or fluoroscopic guidance for this routine injection. Therefore the request is not medically necessary.