

Case Number:	CM15-0218056		
Date Assigned:	11/09/2015	Date of Injury:	03/04/2008
Decision Date:	12/21/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	11/05/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 male who sustained an industrial injury on 3-4-08. A review of the medical records indicates he is undergoing treatment for joint pain in bilateral shoulders, lumbosacral neuritis, and lumbar post-laminectomy syndrome. He also has a history of osteoarthritis and hypertension. Medical records (5-27-15, 9-2-15, and 10-7-15) indicate ongoing complaints of low back pain, right hip pain, and left shoulder pain. He has rated his left shoulder pain "5-7 out of 10." The 10-7-15 record indicates that he "believes" his shoulder pain may be increased due to "sleeping on it wrong." He reports that he is limited in his ability to complete household chores, indicating that he can "do very light" housework without assistance, and he is unable to do any lifting, pushing, or pulling greater than 5 pounds. The physical exam (10-7-15) reveals pain and arthritis in the left shoulder. Muscle strength testing is noted to be "5 out of 5" throughout the upper extremities. Grip strength is noted to be "strong and symmetric." No sensory deficits are noted. Pain is noted with all ranges of motion in the left shoulder. Limited range of motion with pain is noted with abduction and external rotation. Diagnostic studies have included an MRI of the left shoulder. Treatment has included use of ice and heat, as well as medications. The treatment recommendation is for continuation of medications as well as an orthopedic injection with an orthopedic provider. The utilization review (10-13-15) includes a request for authorization of left shoulder subacromial injection. The request was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder subacromial injection: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Steroid injections.

Decision rationale: The claimant sustained a work injury in March 2008. He has a history of a multilevel lumbar fusion in 2009 and underwent a spinal cord stimulator implant in December 2010. He continues to be treated for chronic pain. He has left shoulder pain and arthroscopic surgery is being considered. When seen in October 2015 he had increasing left shoulder pain. Physical examination findings included left shoulder pain with range of motion which was significantly limited. He had pain with abduction and external rotation. There was a diagnosis of adhesive capsulitis. Prior treatments had included joint injections. A left subacromial injection was requested. A steroid injection is recommended as an option which shoulder pain is not controlled adequately by recommended conservative treatments including physical therapy, exercise, and medications after at least three months. Criteria include a diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems. In this case, a subacromial injection is being requested which would be for the treatment of rotator cuff syndrome. The claimant has pain with resisted abduction and external rotation consistent with this diagnosis. Prior joint injections have been performed which would be for a different indication. The requested injection is medically necessary.