

<b>Case Number:</b>	CM15-0055208		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	01/28/2010
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	03/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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

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 51 year old female, who sustained an industrial injury on 1/28/2010. She reported straining her left shoulder and twisting her neck. Diagnoses have included bilateral shoulder pain. Treatment to date has included physical therapy, massage therapy, chiropractic treatment and medication. According to the Primary Treating Physician's Progress Report dated 2/27/2015, the injured worker complained of shoulder pain. Her current pain level was rated 6/10 and was described as aching in her right shoulder. Physical exam revealed pain and tenderness to palpation of the right and left shoulder. Range of motion was decreased due to pain. Authorization was requested for right and left shoulder injection under ultrasound guidance and a urine drug screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder injection under ultrasound guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Criteria for Steroid Injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 204 and 213. Decision based on Non-MTUS Citation Official Disability guidelines Shoulder (Acute & Chronic) Chapter, Steroid injections.

**Decision rationale:** Based on the 02/24/15 progress report provided by treating physician, the patient presents with bilateral shoulder pain rated 6/10. The request is for RIGHT SHOULDER INJECTION UNDER ULTRASOUND GUIDANCE. Patient's diagnosis per Request for Authorization form dated 12/19/14 includes shoulder joint pain. Physical examination on 02/27/15 revealed tenderness to palpation of the right and left shoulder, with decreased range of motion. Conservative treatment to date included physical therapy, chiropractic, massage therapy and acupuncture, which provided partial, brief, temporary relief. Patient medications include Mobic, Tramadol, Gabapentin, Nortriptyline, Wellbutrin, Metoprolol, Ranexa, Omeprazole, Estradiol, and Lipitor. Patient's work status is not available. ACOEM page 204, Chapter 9, Shoulder, initial care 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 nonsteroidal 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. ACOEM page 213, Chapter 9 states: "Two or three subacromial 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. Diagnostic lidocaine injections to distinguish pain sources in the shoulder area (e.g., impingement)." ODG Guidelines, Shoulder (Acute & Chronic) Chapter, under Steroid injections states: "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 (e.g., 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." Per progress report dated 02/27/15, treater plans "right shoulder injection under ultrasound guidance done in office followed by Left shoulder under ultrasound guidance done in office. This is an attempt to avoid hospitalization or surgery. The goal of this therapy is to decrease pain and inflammation so that the patient can better tolerate physical therapy and slow the progression of the disease." It does not appear the patient had prior injections. While the injection may benefit the patient, it is unclear why treater is requesting ultrasound guidance, as it is generally not recommended for this procedure. ODG states "Generally performed without fluoroscopic or ultrasound guidance." The requested ultrasound guidance is excessive and not supported by guidelines. Therefore, the request IS NOT medically necessary.

**Left shoulder injection under ultrasound guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Criteria for Steroid Injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204 and 213. Decision based on Non-MTUS Citation Official disability guidelines, Shoulder (Acute & Chronic) Chapter, Steroid injections.

**Decision rationale:** Based on the 02/24/15 progress report provided by treating physician, the patient presents with bilateral shoulder pain rated 6/10. The request is for LEFT SHOULDER INJECTION UNDER ULTRASOUND GUIDANCE. Patient's diagnosis per Request for Authorization form dated 12/19/14 includes shoulder joint pain. Physical examination on 02/27/15 revealed tenderness to palpation of the right and left shoulder, with decreased range of motion. Conservative treatment to date included physical therapy, chiropractic, massage therapy and acupuncture, which provided partial, brief, temporary relief. Patient medications include Mobic, Tramadol, Gabapentin, Nortriptyline, Wellbutrin, Metoprolol, Ranexa, Omeprazole, Estradiol, and Lipitor. Patient's work status is not available. ACOEM page 204, Chapter 9, Shoulder, initial care 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 nonsteroidal 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. ACOEM page 213, Chapter 9 states: "Two or three subacromial 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. Diagnostic lidocaine injections to distinguish pain sources in the shoulder area (e.g., impingement)." ODG Guidelines, Shoulder (Acute & Chronic) Chapter, under Steroid injections states: "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 (e.g., 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." Per progress report dated 02/27/15, treater plans "right shoulder injection under ultrasound guidance done in office followed by Left shoulder under ultrasound guidance done in office. This is an attempt to avoid hospitalization or surgery. The goal of this therapy is to decrease pain and inflammation so that the patient can better tolerate physical therapy and slow the progression of the disease." It does not appear the patient had prior injections. While the injection may benefit the patient, it is unclear why treater is requesting ultrasound guidance, as it is generally not recommended for this procedure. ODG states "Generally performed without fluoroscopic or ultrasound guidance." The requested ultrasound guidance is excessive and not supported by guidelines. Therefore, the request IS NOT medically necessary.

**Urine drug screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going management. Decision based on Non-MTUS Citation Official Disability Guidelines, Criteria for Use of Urine Drug Testing, Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official disability guidelines, Pain chapter, Urine drug testing.

**Decision rationale:** Based on the 02/24/15 progress report provided by treating physician, the patient presents with bilateral shoulder pain rated 6/10. The request is for URINE DRUG SCREEN. Patient's diagnosis per Request for Authorization form dated 12/19/14 includes shoulder joint pain. Diagnosis on 02/24/14 included long-term (current) use of other medications. Physical examination on 02/27/15 revealed tenderness to palpation of the right and left shoulder, with decreased range of motion. Conservative treatment to date included physical therapy, chiropractic, massage therapy and acupuncture, which provided partial, brief, temporary relief. Patient medications include Mobic, Tramadol, Gabapentin, Nortriptyline, Wellbutrin, Metoprolol, Ranexa, Omeprazole, Estradiol, and Lipitor. Patient's work status is not available. MTUS Chronic Pain Medical Treatment Guidelines, page 43 has the following under Drug Testing: "Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. For more information, see Opioids, criteria for use: (2) Steps to Take before a Therapeutic Trial of Opioids & (4) On-Going Management; Opioids, differentiation: dependence & addiction; Opioids, screening for risk of addiction (tests); & Opioids, steps to avoid misuse/addiction." ODG-TWC, Pain (Chronic) Chapter, under Urine drug testing (UDT), has the following criteria regarding Urine Drug Screen: "Patients at low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders." Per progress report dated 02/24/15, treater states urine toxicology screen "performed in office for medication verification and possible narcotic prescribing." Laboratory reports dated 12/17/14 and 01/21/14 were provided with medical records. MTUS does not specifically discuss the frequency that urine drug screens should be performed. ODG is more specific on the topic and recommends urine drug screens on a yearly basis if the patient is at low risk; for moderate risk, 3-4 UDS's are recommended, and for high risk as often as once per month. Treater does not explain why another UDS needs to be certified and there is no discussion that the patient is at high risk for adverse outcomes, or has active substance abuse disorder. Therefore, the request IS NOT medically necessary.