

<b>Case Number:</b>	CM15-0056162		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	04/07/2000
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	03/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2015

### 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 & General Preventive Medicine

### 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 female, who sustained an industrial injury on 04/07/2000. She has reported subsequent left shoulder pain radiating to the head and was diagnosed with shoulder joint pain. Treatment to date has included oral pain medication, physical therapy and surgery. In a progress note dated 03/02/2015, the injured worker complained of worsening left shoulder pain radiating to the neck and head that was rated as 5-6/10. There was no documentation of objective physical examination findings of the shoulder. A request for authorization of ultrasound and injection of the left shoulder was made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Injection, left shoulder, per 03/03/15 quantity: 1.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-252. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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 (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. The patient has had prior rotator cuff surgeries, there is documentation of those surgeries. The treating physician documents failure of conservative therapy, decreased function on current pain medications and the goal of the shoulder injection to improve pain control. As such, the request for Injection, left shoulder, per 03/03/15 quantity: 1.00 is medically necessary.

**Ultrasound, left shoulder, per 03/03/15 order quantity 1.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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 (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. The patient has had prior rotator cuff surgeries; there is documentation of those surgeries. The treating physician documents failure of conservative therapy, decreased function on current pain medications and the goal of the shoulder injection to

improve pain control . As such, the request for Injection, left shoulder, per 03/03/15 quantity:  
1.00 is not medically necessary. As such, the request for Ultrasound, left shoulder, per 03/03/15  
order quantity 1.00 is medically necessary.