

<b>Case Number:</b>	CM15-0089406		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	11/07/2012
<b>Decision Date:</b>	06/15/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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: Connecticut, California, Virginia  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 57 year old female, who sustained an industrial injury on 11/07/2012. She has reported injury to the neck, right shoulder, right foot, and low back. The diagnoses have included cervical strain with right upper extremity cervical radiculitis; right shoulder pain with partial, possible full-thickness rotator cuff tear; low back strain with right lower extremity L5 lumbar radiculitis; and right heel plantar fasciitis. Treatment to date has included medications, diagnostics, and injections. Medications have included Advil, Meloxicam, and Omeprazole. A report from the treating physician, dated 02/19/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of right shoulder pain; posterior neck, right upper extremity, and right hand pain with numbness and paresthesias; and low back pain with bilateral lower extremity right greater than left pain, numbness and paresthesias, L5 to anterior lower legs and plantar feet. Objective findings included positive impingement and supraspinatus signs, and positive acromioclavicular joint tenderness and crepitus to the bilateral shoulders; tenderness to palpation of the paracervical, levator scapulae, medial trapezius, and parascapular muscles; decreased lumbar range of motion; and positive straight leg raise on the right. The treatment plan has included the request for cortisone injection of the right shoulder; and physical therapy with traction, evaluation, therapeutic exercise, and neuromuscular re-education, right shoulder, neck, and low back, quantity: 8.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cortisone injection of the right shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter, corticosteroid injection.

**Decision rationale:** The ODG guidelines provide a detailed mechanism with which to evaluate for corticosteroid injections of the shoulder. Criteria for injections include: 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. Overall in this case, the provided documents indicate that the patient has impingement signs in the shoulder, but it is unclear due to the lack of records whether or not the patient has failed conservative treatment. Therefore it cannot be determined that the patient meets the criteria set by the guidelines and the request is not medically necessary at this time.

**Physical therapy with traction, evaluation, therapeutic exercise, and neuromuscular re-education, right shoulder, neck, and low back, QTY: 8: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): 58-59.

**Decision rationale:** The MTUS Chronic Pain Management Guidelines (pg 58-59) indicate that manual therapy and manipulation are recommended as options. With respect to therapeutic care, the MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement allowing for up to 18 visits over 6-8 weeks. If the case is considered a recurrence/flare-up, the guidelines similarly indicate a need to evaluate treatment success. In either case, whether considered acute or recurrent, the patient needs to be evaluated for functional improvement prior to the completion of 12 visits in order to meet the standards outlined in the guidelines. Overall, the majority of records provided are extremely sparse on objective exam findings and provide little insight into the patient's overall condition. Re-

evaluation for efficacy of treatment/functional improvement is critical, and the request for 8 total visits prior to follow up for evaluation is not appropriate. The guidelines indicate a time to produce effect of 4-6 treatments, which provides a reasonable timeline by which to reassess the patient and ensure that education, counseling, and evaluation for functional improvement occur. In this case, the patient may benefit from physical therapy, but the request for a total of 8 visits to physical therapy without a definitive plan to assess for added clinical benefit prior to completion of the entire course of therapy is not medically necessary.