Case Number:	CM15-0089478		
Date Assigned:	05/13/2015	**Date of Injury:**	03/30/2013
Decision Date:	06/18/2015	**UR Denial Date:**	04/21/2015
Priority:	Standard	**Application Received:**	05/09/2015

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: New Jersey
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:

This female sustained an industrial injury to the right shoulder on 3/30/13. Previous treatment included magnetic resonance imaging, physical therapy and medications. The injured worker subsequently sustained an industrial injury to the back and left shoulder on 9/5/13. The injured worker underwent right shoulder surgery (10/2013) and right shoulder manipulation (5/2014). The injured worker received postoperative physical therapy, chiropractic therapy and medications. In an Initial Primary Treating Physician's Evaluation and Request for Authorization dated 3/17/15, the injured worker complained of bilateral shoulder pain and burning with pain in the right chest region that radiated into bilateral upper arms and low back pain with radiation into the buttocks and legs. X-rays right shoulder (3/17/15) showed a type 2 acromion and degenerative spurring of the distal clavicle. Magnetic resonance imaging right shoulder showed tendinosis and degenerative changes. Magnetic resonance imaging lumbar spine showed multilevel degenerative disc disease with facet disease and disc protrusion. Current diagnoses included status post right shoulder surgery with residual subacromial inflammation and impingement syndrome, left shoulder rotator cuff tear and impingement syndrome, lumbar spine radiculitis, chronic lumbar pain and reactive depression. The injured worker received a right shoulder injection during the office visit. The treatment plan included a right shoulder subacromial cortisone injection, resuming the injured worker's anti-inflammatory medications, physical therapy referral, referral to a lumbar spine specialist and a psychological consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural Steroid Injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections, p. 46.

Decision rationale: The MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of lumbar radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and can offer short-term pain relief, but use should be in conjunction with other rehab efforts, including continuing a home exercise program. The criteria as stated in the MTUS Guidelines for epidural steroid injection use for chronic pain includes the following: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing, 2. Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants), 3. Injections should be performed using fluoroscopy for guidance, 4. If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections, 5. No more than two nerve root levels should be injected using transforaminal blocks, 6. No more than one interlaminar level should be injected at one session, 7. in the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pan relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, and 8. Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase, and instead only up to 2 injections are recommended. In the case of this worker, there was insufficient evidence presented to suggest a specific lumbar spinal level was causing radicular pain to warrant a steroid injection. Previous injections reportedly had been unsuccessful. Also, the request did not include a spinal level to be injected. Therefore, considering the factors above, the request for "epidural steroid injections" will be considered medically unnecessary.

MRI arthrogram right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The MTUS Guidelines state that special testing such as MRIs for most patients with shoulder problems are not needed unless a four to six-week period of conservative

care and observation fails to improve symptoms and are not recommended earlier than this unless red flags are noted on history or examination that raise suspicion of a serious shoulder condition. Muscle strains do not warrant special testing. Even cases of impingement or muscle tears of the shoulder area should be treated conservatively first, and only when considering surgery would testing such as MRI be helpful or warranted. After the initial course of conservative treatment over the 4-6 week period after the injury, MRI may be considered to help clarify the diagnosis in order to change the plan for reconditioning. The criteria for MRI of the shoulder include 1. Emergence of a red flag (intra-abdominal or cardiac problems presenting as shoulder problems), 2. Physiologic evidence of tissue insult or neurovascular dysfunction such as cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis, or Raynaud's phenomenon, 3. Failure to progress in a strengthening program intended to avoid surgery, and 4. Clarification of the anatomy prior to an invasive procedure such as in the case of a full thickness tear not responding to conservative treatment. When surgery is being considered for a specific anatomic defect (e.g.,a full-thickness rotator cuff tear). Magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy although MRI is more sensitive and less specific. MR arthrography may be indicated in cases where labral tear is suspected or when there is a suspected retear of a rotator cuff after surgical repair. In the case of this worker, there was insufficient evidence of any significant change in symptoms to suggest any imaging was warranted. Also, although there was mention of possible surgical intervention on the shoulder, a steroid injection and physical therapy was ordered and not yet followed up on to justify ordering MR arthrography before this information is available. Therefore, the request for MRI arthrogram of the right shoulder will be considered medically unnecessary at this time.