

Case Number:	CM14-0125662		
Date Assigned:	08/11/2014	Date of Injury:	09/03/2013
Decision Date:	09/30/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/08/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a male patient with a date of injury of September 3, 2013. A utilization review determination dated July 25, 2014 recommends non-certification of one fluoroscopically guided left L5 - S1 epidural injection and one right shoulder cortisone injection. The only progress note available for review was dated August 1, 2014 and identifies subjective complaints of right low back pain, right shoulder pain, and right lower extremity pain. The patient has already had a right shoulder cortisone injection recently. The patient's pain is exacerbated with prolonged sitting, prolonged standing, lifting, twisting, driving, and any activities, lying down, and bearing down. Current medications include ibuprofen and Flexeril. Physical examination identifies tenderness upon palpation of the lumbar paraspinal muscles and of the right shoulder, shoulder range of motion is restricted by pain in all directions, right shoulder impingement signs including Neer's and Hawkin's are positive, lumbar range of motion is restricted by pain in all directions, lumbar extension is worse than lumbar flexion, lumbar discogenic provocative maneuver and sustained hip flexion were positive on the right, sacroiliac provocative maneuver and pressure at the sacral sulcus were positive on the right, muscle strength reflexes were one and symmetric bilaterally and all lands, muscle strength is 5/5 in all limbs except for 4/5 muscle strength in the left tibialis anterior and left peroneal, and sensation is intact to light touch, pinprick, proprioception, and vibration in all limbs. Diagnoses include broad-based and left lateral disc protrusion at L5 - S1 measuring 3 - 4 mm and touching the left L5 nerve with severe neuroforaminal stenosis and facet hypertrophy, lumbar disc protrusion, lumbar radiculopathy, lumbar facet pain, lumbar facet joint arthropathy, lumbar stenosis, and right shoulder impingement. The treatment plan recommends a fluoroscopically guided left L5 - S1 epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Fluoroscopically Guided Left L5-S1 Epidural Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injection.

Decision rationale: Regarding the request 1 fluroscopically guided left L5-S1 epidural injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Guidelines recommend that no more than one interlaminar level, or two transforaminal levels, should be injected at one session. Regarding repeat epidural injections, guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain 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. Within the documentation available for review, there are no specific subjective complaints supporting a diagnosis of radiculopathy, or mention of failure of conservative treatment. In the absence of such documentation, the currently requested 1 fluroscopically guided left L5-S1 epidural injection is not medically necessary.

1 RT Shoulder Cortisone Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Shoulder Page(s): 24. Decision based on Non-MTUS Citation (ODG) Shoulder.

Decision rationale: Regarding the request for 1 right shoulder cortisone injection, Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative treatment for 2 or 3 weeks. They go on to recommend the total number of injections should be limited to 3 per episode, allowing for assessment of benefits between injections. Official Disability Guidelines recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, when pain interferes with functional activities. Guidelines state that a 2nd injection is not recommended if the 1st has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, there is no mention of failure of conservative treatment. Additionally, there is no mention of any significant analgesic efficacy or objective functional improvement from the right shoulder cortisone injection recently performed. As such, the currently requested 1 right shoulder cortisone injection is not medically necessary.

