

<b>Case Number:</b>	CM14-0144452		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	12/08/2013
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2014

### 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 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:

The injured worker is a 71 year old male with a date of work-related injury on December 8, 2013. As per the progress notes from July 7, 2014, the injured worker returned to his provider for a follow-up visit. He reported that a requested magnetic resonance imaging was not authorized. No objective findings were found. He is diagnosed with chronic subacromial bursitis of the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Injection with 3cc 1-5 percent macraïne and 1 cc depomedrol 45 mg right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Criteria for steroid injections

**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, Steroid Injection

**Decision rationale:** According to evidence-based guidelines, the criteria for steroid injections include the 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, nonsteroidal anti-inflammatory drugs, 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; and is generally performed without fluoroscopic or ultrasound guidance. A review of this injured worker's medical records does not indicate that he has met the aforementioned criteria. Moreover, the provider indicated that that his diagnosis of bursitis is accurate and is doubtful of a rotator cuff tear. This means that primarily the injured worker does not meet any of indications for steroid injections. Therefore, the medical necessity of the requested 3cc 1-5 percent Marcaine and 1 cc Depo-Medrol 45 milligrams to the right shoulder is not established. Therefore the request is not medically necessary.