

Case Number:	CM14-0177957		
Date Assigned:	10/31/2014	Date of Injury:	08/29/2013
Decision Date:	12/08/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/27/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine 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 had an original date of injury of August 29, 2013. The industrial diagnoses include chronic shoulder pain, sprain and strain of the shoulder and upper arm, and impingement syndrome. The patient has had conservative therapy with kinesiotaping, physical therapy, activity modification, and pain medication. The diagnostic workup has consisted of an MRI of the right shoulder without contrast that was performed on October 29, 2013. This demonstrated a hypertrophic arthrosis of the acromioclavicular joints, outlet impingement, and supraspinatus tendinosis. The disputed issues a request for shoulder injection. This was denied in a utilization review determination on date of service October 7, 2014. The rationale for the denial was that there was no mention of whether the injured worker had benefit with prior injection administered to the right shoulder, and therefore the medical necessity of this injection is not established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Injection to the right shoulder: 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 Shoulder Injection Section Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Injection Topic

Decision rationale: Regarding the request for shoulder 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 a lack of documentation that the patient had any significant analgesic efficacy or objective functional improvement from the previous shoulder injection. There are no recent notes that address the outcome or even the date of the prior injection. As such, the currently requested shoulder injection is not medically necessary.