

Case Number:	CM14-0093168		
Date Assigned:	07/25/2014	Date of Injury:	10/19/2010
Decision Date:	10/07/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/19/2014

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 Texas & Oklahoma. 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 61-year-old female with a reported injury on 10/19/2010. The mechanism of injury was due to she sustained a concussion to the head without coma when she had just finished her break and squatted down to put food back in her refrigerator, another associate opened the freezer door, hitting her head on the freezer door while getting up. Her diagnoses consisted of cervical disc displacement, sprain of neck, cervical disc degeneration, lumbosacral disc degeneration, rotator cuff syndrome, and carpal tunnel syndrome. The injured worker had an examination on 05/20/2014 with complaints of chronic neck pain and stiffness with radiation to the bilateral upper extremities with pain and tingling. She complained of right shoulder pain, weakness and popping. It was discussed in her report that the doctor had recommended pain management for epidurals of the neck and low back and that they have not been done yet. It was also discussed that the injured worker should have a right shoulder surgery that has not been performed. There was no documentation regarding motor strength, sensation, or reflexes. There were no pain medications that were listed. The recommended plan of treatment was for the injured worker to have a subacromial injection to further delineate the nature of her right upper extremity symptoms, separating the right arm from the right shoulder. The Request for Authorization was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Injections

Decision rationale: The request for Right shoulder injection is not medically necessary. The request does not specify as to what type of injection is to be performed. The medical evaluation does suggest a subacromial injection. The California MTUS/ACOEM Guidelines do not address this particular request. The Official Disability Guidelines state there is limited research to support the routine use of subacromial injections for pathological processes involving the rotator cuff, but this treatment can be offered to patients. Subacromial injections can be helpful to distinguish between shoulder weaknesses caused by impingement or true rotator cuff tear. The criteria for the injections recommend there should be a diagnosis of adhesive capsulitis, Impingement syndrome, or rotator cuff problems except for post traumatic impingement of the shoulder. Also, they are recommended if pain has not been controlled adequately by recommended conservative treatments such as physical therapy, exercise, NSAIDs and/or acetaminophen for at least 3 months. It is recommended if pain interferes with functional activities. There was a lack of evidence of conservative treatment such as physical therapy, exercise, NSAIDs or acetaminophen. There was no list of medications provided, or the efficacy. There was a lack of documentation that noted that the pain interfered with functional activities. Furthermore, the request does not specify as to what type of injection was to be performed and there is a lack of evidence to support the medical necessity without further evaluation and assessment. The clinical information fails to meet the evidence based guidelines for the request. Therefore, the request for Right shoulder injection is not medically necessary.