

Case Number:	CM15-0018720		
Date Assigned:	02/06/2015	Date of Injury:	02/14/2013
Decision Date:	03/30/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	02/02/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 (IW) is a 44 year old Male who sustained an industrial injury on 02/14/2013 when he fell. He has reported right shoulder pain and pain in the right elbow, shoulder and back. Diagnoses include right shoulder internal derangement and positive impingement of the right shoulder. Treatment to date has included medications, physiotherapy and a right foot tarsal tunnel cortisone injection under ultrasound guidance done in the office in July 2014. Tests include MRI scans of the right shoulder, right elbow, and lumbar spine. Electromyogram /nerve conduction study done in February 2014 was consistent with right tarsal tunnel syndrome. The MRI of the back showed lumbar degenerative disc disease L4-5, L5-S1, lumbar discopathy L4-6 and L5-S1. The MRI of the shoulder done in February showed right shoulder acromioclavicular joint hypertrophy, arthrosis, and supraspinatus tendinosis. The right elbow MRI was normal. A progress note from the treating provider dated 12/22/2014 indicates subjective complaints of back and right shoulder pain. Right shoulder has limited range of motion and weakness with positive impingement of right shoulder. Treatment plan includes a right cortisone injection to the subacromial space. And right L4-5 and L5-S1 epidural injection under fluoroscope. On 01/07/2015 Utilization Review non-certified a request for Right shoulder cortisone injection into the subacromial space under ultrasound guidance noting the there was a lack of documentation of conservative treatment including physical therapy and nonsteroidal anti-inflammatories for at least 2-3 weeks before considering a cortisone injection. The guidelines do not support the use of ultrasound with subacromial cortisone injections. The ACOEM Guidelines Chapter 9 Shoulder Complaints were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder cortisone injection into the subacromial space under ultrasound guidance:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Treatment Workers Compensation, Treatment - Shoulder: Steroid injection

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter, Steroid injections

Decision rationale: Per the 12/22/14 report the patient presents with continued right shoulder pain. Reports included diagnoses of right shoulder internal derangement and shoulder impingement syndrome. The current request is for RIGHT SHOULDER CORTISONE INJECTION INTO THE SUBACROMIAL SPACE UNDER ULTRASOUND GUIDANCE per the 12/30/14 RFA. As of 12/22/14 the patient is to remain off work until 02/03/15. ODG, Shoulder Chapter, Steroid injections, states, "Recommended as indicated below, up to three injections. Steroid injections compared to physical therapy seem to have better initial but worse long-term outcomes. Criteria include: Generally performed without fluoroscopic or ultrasound guidance."The treater states this request is per the AME. In this case, criteria for steroid injections includes impingement syndrome which is documented for this patient. However, this request includes ultrasound guidance which is not supported by ODG. The reports do not explain why ultrasound guidance is needed in this case. The request IS NOT medically necessary.