

<b>Case Number:</b>	CM15-0113909		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	11/02/2008
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	05/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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:

This is a 56 year old female with a November 2, 2008 date of injury. Current diagnoses include (chronic neck pain with right cervicobrachial myofascial pain syndrome; cervical sprain/strain and aggravation of underlying degenerative changes; mild degenerative spondylosis of the mid cervical spine; acquired right cervical dystonia; right shoulder pain due to sprain/strain; supraspinatus and infraspinatus tendinosis; mild subdeltoid bursitis; type II acromion and mild acromioclavicular arthrosis; degenerative changes and tearing of the superior aspect of the labrum; chronic right elbow pain due to sprain/strain; right medial neuropathy; median nerve entrapment; carpal tunnel syndrome; left shoulder sprain/strain). A progress note dated April 9, 2015 documents subjective complaints (increased neck pain that radiates to the upper extremities bilaterally; shoulder pain bilaterally; injured worker reports swelling and decreased range of motion of the right shoulder; insomnia due to pain), objective findings (tenderness to palpation across the lower neck; decreased range of motion of the cervical spine; neck tilted to the right side; decreased range of motion of the right shoulder; tenderness to palpation at the acromioclavicular joint; positive impingement signs; positive rotator cuff provocative tests; decreased grip strength in the right hand; decreased sensation to pinprick at the right fifth and third digits). Treatments to date have included medications, right shoulder surgery, carpal tunnel release, injections, and imaging studies. The treating physician documented a plan of care that included a corticosteroid injection to the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Corticosteroid injections with ultrasonic guidance for needle placement (left shoulder):**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Integrated Treatment/Disability Duration Guidelines: Shoulder (Acute & Chronic & Steroid Injections).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Chapter 9, Shoulder Complaints, pages 204, 207; Table 9-6, page 213.

**Decision rationale:** There is no specific failed conservative treatment noted to meet criteria of corticosteroid injection nor has there been clear documented functional improvement by way of ADLs or decrease in medication dosing or medical utilization to support current request. Guidelines states if pain with elevation is significantly limiting activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and NSAIDs) for two to three weeks, but the evidence is not yet overwhelming, and the total number of injections should be limited to no more than three. Although injections into the subacromial space and acromioclavicular joint can be performed in the clinician's office, injections into the glenohumeral joint should only be performed under fluoroscopic guidance. A recent meta-analysis concluded that subacromial corticosteroid injection for rotator cuff disease and intra-articular injection for adhesive capsulitis may be beneficial although their effect may be small and not well maintained. Additionally, for post-traumatic impingement of the shoulder, subacromial injection of methylprednisolone had no beneficial impact on reducing the pain or the duration of immobility. Submitted reports have not specified limitations with activities, functional improvement from previous injection, progressive changed clinical deficits, failed conservative treatment, acute flare-up, red-flag conditions, or new injury to support for this shoulder injection. The Corticosteroid injections with ultrasonic guidance for needle placement (left shoulder) is not medically necessary and appropriate.