

Case Number:	CM15-0119956		
Date Assigned:	06/30/2015	Date of Injury:	06/25/2014
Decision Date:	07/29/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/22/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 58 year old male, who sustained an industrial injury on 06/25/2014. The injured worker reported sustaining injuries secondary to a client falling onto the right side of the injured worker. The injured worker was diagnosed as having lumbar four to five and lumbar five to sacral one disc disease with stenosis, right lumbosacral radiculopathy, diabetes, and status post cardiac stent with anticoagulant therapy. Treatment and diagnostic studies to date has included laboratory studies, physical therapy, medication regimen, magnetic resonance imaging of the lumbar spine, x-rays of the lumbar spine, lumbar five to sacral one transforaminal epidural injection, right shoulder injection, and use of a cane. In a progress note dated 05/07/2015 the treating physician reports complaints of low back pain that radiates to the right lower extremity to the foot. Examination reveals mild right antalgic gait, discomfort with toe-walk and heel-walk, pain with lumbar range of motion, restricted range of motion to the patella, pain on palpation to the right lower back, trace reflexes to the knees and ankles, positive short leg raise on the right, and decreased strength to the bilateral lower extremities. The treating physician noted that the injured worker is under the care of another physician for his right shoulder, but the medical records provided did not provide the injured worker's current signs or symptoms of the right shoulder. The treating physician noted that prior right shoulder injection provided improvement to the injured worker, but the documentation did not provide specific details with regards to functional improvement. The treating physician requested ultrasound guidance for cortisone injection to the right shoulder per order on 05/18/2015 with a quantity of one, noting prior injection to the right shoulder, but the documentation did not indicate the specific reason for the requested treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound guidance for cortisone injection, right shoulder, per 05/18/15 order, Qty: 1.00:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Version, Criteria for Steroid Injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Steroid injection <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, shoulder injection is recommended: Criteria for Steroid injections: 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, NSAIDs 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. Generally performed without fluoroscopic or ultrasound guidance. Only one injection should be scheduled to start, rather than a series of three. A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response. With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option. The number of injections should be limited to three. There is no recent documentation of failure of conservative therapies including medication and physical therapy. There is no documentation of adhesive capsulitis, impingement syndrome, or rotator cuff problems. There is no objective documentation of efficacy of previous shoulder injection. Therefore the request for Ultrasound guidance for cortisone injection, right shoulder, per 05/18/15 order, Qty: 1.00 is not medically necessary.