

Case Number:	CM15-0120559		
Date Assigned:	07/01/2015	Date of Injury:	10/19/2012
Decision Date:	08/25/2015	UR Denial Date:	05/22/2015
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: 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 is a 54-year-old male, who sustained an industrial injury on October 19, 2012, incurring injuries to the left shoulder. Magnetic Resonance Imaging of the left shoulder revealed degeneration of the superior labrum of the left shoulder. He was diagnosed with left shoulder tendonitis, bursitis and cervicalgia. Treatment included anti-inflammatory drugs, proton pump inhibitor, orthopedic, neurology consultations, and work modifications. Currently, the injured worker complained of persistent neck and left shoulder pain radiating to the left arm. He rates the pain 7/10 on a pain scale of 1 to 10 with pain medications and 9/10 without analgesics. He complained of restricted range of motion of the cervical spine and left shoulder. He noted difficulty-sleeping secondary to pain. The treatment plan that was requested for authorization included a Cortisone injection to the left shoulder, injection of Lidocaine for intravenous infusion, injection of Trimoinolone Acetonide and ultrasound guidance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cortisone injection to the left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 213, 235, 236.

Decision rationale: The patient was injured on 10/19/12 and presents with neck and left shoulder pain which radiates to the left arm. The request is for a CORTISONE INJECTION TO THE LEFT SHOULDER. The utilization review determination rationale is that "there was no documentation of the conservative treatment rendered." There is no RFA provided and the patient is "placed on modified duty with restrictions of no lifting or carrying greater than 10 pounds, no pushing or pulling greater than 10 pounds, and no left upper extremity grasping and torturing. No driving." The report with the request is not provided. Review of the medical records provided does not indicate if the patient had a prior cortisone injection to the left shoulder. ACOEM guidelines page 235 and 236 states "corticosteroid injections have been shown to be effective, at least in the short term; however, the evidence on long-term effects is mixed, some studies show high recurrence rate among injection groups." For shoulder, ACOEM page 213 allows for 2-3 injections as part of a rehabilitation program. ODG guidelines recommend up to 3 injections. The reason for the request is not provided. There is tenderness to palpation over the bilateral cervical paraspinal muscles. The patient is diagnosed with cervicalgia and disorders of bursae and tendon in shoulder region. Treatment to date includes anti-inflammatory drugs, proton pump inhibitor, orthopedic and neurology consultations, and work modifications. Given the patient's continued left shoulder pain and positive exam findings, a trial of left shoulder cortisone injection is within guidelines. The request IS medically necessary.

Injection lidocaine hel for intravenous infusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Page(s): 111.

Decision rationale: The patient was injured on 10/19/12 and presents with neck and left shoulder pain which radiates to the left arm. The request is for INJECTION LIDOCAINE GEL FOR INTRAVENOUS INFUSION. There is no RFA provided and the patient is "placed on modified duty with restrictions of no lifting or carrying greater than 10 pounds, no pushing or pulling greater than 10 pounds, and no left upper extremity grasping and torqueing. No driving." The report with the request is not provided. Review of the medical records provided does not indicate if the patient had a prior lidocaine injection. Regarding Lidocaine, MTUS Guidelines page 111 states Lidocaine is only allowed in a patch form and not allowed in cream, lotion or gel forms. The reason for the request is not provided. There is tenderness to palpation over the bilateral cervical paraspinal muscles. The patient is diagnosed with cervicalgia and disorders of bursae and tendon in shoulder region. Treatment to date includes anti-inflammatory drugs, proton pump inhibitor, orthopedic and neurology consultations, and work modifications. Due to lack of support from MTUS Guidelines, the requested Lidocaine gel injection IS NOT medically necessary.

Injection, triamcinolone acetonide, not otherwise specified: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 9 Shoulder Complaints Page(s): 213, 235, 236.

Decision rationale: The patient was injured on 10/19/12 and presents with neck and left shoulder pain which radiates to the left arm. The request is for INJECTION, TRIAMCINOLONE ACETONIDE, NOT OTHERWISE SPECIFIED. The utilization review letter did not provide a rationale. There is no RFA provided and the patient is "placed on modified duty with restrictions of no lifting or carrying greater than 10 pounds, no pushing or pulling greater than 10 pounds, and no left upper extremity grasping and torturing. No driving." The report with the request is not provided. Review of the medical records provided does not indicate if the patient had a prior triamcinolone acetonide injection to the left shoulder. Triamcinolone acetonide is "a synthetic glucocorticoid corticosteroid with marked anti-inflammatory action." ACOEM guidelines page 235 and 236 states "corticosteroid injections have been shown to be effective, at least in the short term; however, the evidence on long-term effects is mixed, some studies show high recurrence rate among injection groups." For shoulder, ACOEM page 213 allows for 2-3 injections as part of a rehabilitation program. ODG guidelines recommend up to 3 injections. The reason for the request is not provided. There is tenderness to palpation over the bilateral cervical paraspinal muscles. The patient is diagnosed with cervicalgia and disorders of bursae and tendon in shoulder region. Treatment to date includes anti-inflammatory drugs, proton pump inhibitor, orthopedic and neurology consultations, and work modifications. Given the patient's continued left shoulder pain and positive exam findings, a trial of triamcinolone acetone injection is within guidelines. The request IS medically necessary.

Ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, under Steroid injections Shoulder Chapter, Ultrasound guidance for shoulder injections.

Decision rationale: The patient was injured on 10/19/12 and presents with neck and left shoulder pain which radiates to the left arm. The request is for ULTRASOUND GUIDANCE. The utilization review determination rationale is that "ultrasound guidance is not needed for a subacromial injection in the shoulder." There is no RFA provided and the patient is "placed on modified duty with restrictions of no lifting or carrying greater than 10 pounds, no pushing or pulling greater than 10 pounds, and no left upper extremity grasping and torqueing. No driving." The report with the request is not provided. ODG Shoulder chapter, under Steroid injections has the following regarding imaging guidance for shoulder injections: "Glucocorticoid injection for shoulder pain has traditionally been performed guided by anatomical landmarks alone, and that is

still recommended. With the advent of readily available imaging tools such as ultrasound, image-guided injections have increasingly become routine. While there is some evidence that the use of imaging improves accuracy, there is no current evidence that it improves patient-relevant outcomes." ODG Shoulder Chapter, Ultrasound guidance for shoulder injections: "In the shoulder, conventional anatomical guidance by an experienced clinician is generally adequate. While ultrasound guidance may improve the accuracy of injection to the putative site of pathology in the shoulder, it is not clear that this improves its efficacy." The reason for the request is not provided. There is tenderness to palpation over the bilateral cervical paraspinal muscles. The patient is diagnosed with cervicalgia and disorders of bursae and tendon in shoulder region. Treatment to date includes anti-inflammatory drugs, proton pump inhibitor, orthopedic and neurology consultations, and work modifications. ODG and ACOEM do support trial of injections for short-term relief. However, ODG Guidelines do not support the requested ultrasound guidance. Therefore, the requested ultrasound guided IS NOT medically necessary.