

<b>Case Number:</b>	CM15-0075739		
<b>Date Assigned:</b>	04/27/2015	<b>Date of Injury:</b>	07/08/2011
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 50 year old male injured worker suffered an industrial injury on 07/08/2011. The diagnoses included cervical spine radiculopathy and right shoulder impingement syndrome. The diagnostics included right shoulder magnetic resonance imaging. The injured worker had been treated with medications. On 3/23/2015 the treating provider reported the right shoulder pain with popping and clicking with the pain and tenderness radiating to the right elbow. The lumbar spine had tenderness. The pain with medications was 4/10 and without medications was 7/10. The treatment plan included Right ultrasound subacromial injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right ultrasound subacromial injection under ultrasound guidance Qty:2:** 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), Shoulder Chapter, Injection Section.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

**Decision rationale:** Regarding the request for Ultrasound-Guided Steroid Injection for the Rt Shoulder, Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative treatment for 2 or 3 weeks. They go on to recommend the total number of injections should be limited to 3 per episode, allowing for assessment of benefits between injections. Official Disability Guidelines recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, when pain interferes with functional activities. Guidelines state that a 2nd injection is not recommended if the 1st has resulted in complete resolution of symptoms, or if there has been no response. Additionally, guidelines do not support the use of imaging guidance for shoulder injections. As such, the currently requested right shoulder injection with ultrasound is not medically necessary.