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| Case Number: | CM14-0030282 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 05/07/2010 |
| Decision Date: | 07/17/2014 | UR Denial Date: | 02/26/2014 |
| Priority: | Standard | Application Received: | 03/10/2014 |

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 48-year-old male who reported an injury on 05/07/2010 after he pulled a strap that broke which caused him to fall on his left side. The injured worker reportedly sustained an injury to his left knee and left shoulder. The injured worker's treatment history included left knee meniscal repair and left shoulder rotator cuff/SLAP repair on 04/13/2011; left knee arthroscopy and meniscectomy on 04/19/2012, epidural steroid injections, physical therapy, and multiple medications. The injured worker was evaluated on 02/18/2014. It was documented that the injured worker had improvement with physical therapy and was able to lift his arm over his head. It was also documented that the patient reported buckling when changing positions while walking and noticed other mechanical symptoms of the left knee. It was noted that the patient had a series of Orthovisc injections in 01/2013 and 08/2013 that provided good relief. It was documented that the patient's symptoms had returned as of 01/2014. It was also noted that the patient was attending aquatic therapy for his low back that also benefited his left knee. Clinical findings of the left shoulder included a positive scapular wing +1, tenderness to the supraspinatus, a positive impingement sign, and limited range of motion. Evaluation of the left knee documented a positive effusion, synovitis, and atrophy with tenderness over the medial joint line and restricted range of motion. It was documented that the patient had subpatellar crepitus. The injured worker's diagnoses included light joint pain, instability of the knee, chondromalacia patella, knee joint crepitus, knee degenerative osteoarthritis, sprain of the knee and leg, joint pain, sprained shoulder, impingement of the shoulder, shoulder sprain/strain of the rotator cuff, bicipital tendonitis and shoulder acromioclavicular joint arthritis. The injured worker's treatment plan included continued physical therapy in an attempt to avoid surgical intervention and a corticosteroid injection to assist with pain control. It was also noted that the patient would benefit from an Orthovisc injection series due to recurrent pain and instability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Eight (8) Physical Therapy visits for the 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) Shoulder Chapter "Adhesive capsulitis".

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested 8 physical therapy visits for the left shoulder is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has participated in extensive physical therapy for the left shoulder. California Medical Treatment Utilization Schedule recommends that injured workers be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. The clinical documentation does not provide any evidence that the patient is participating in a home exercise program. Therefore, a short course of physical therapy would benefit the patient to transition them into a home exercise program; however, the requested 8 physical therapy visits would be considered excessive. As such, the requested 8 physical therapy visits for the left shoulder is not medically necessary or appropriate.

Cortisone Injection left Shoulder with ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS 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, Imaging guidance for shoulder injections.

Decision rationale: The requested corticosteroid injection of the left shoulder with ultrasound guidance is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has significant pain complaints that would benefit from a corticosteroid injection; however, California Medical Treatment Utilization Schedule does not specifically address the use of ultrasound guidance for corticosteroid injections. Official Disability Guidelines do not support the use of ultrasound guidance over the use of anatomical landmarks to assist with correct injection placement. The clinical documentation does not provide any evidence that the treating provider could not use traditional anatomical landmarks and would need ultrasound guidance. As such, the requested cortisone injection of the left shoulder with ultrasound guidance is not medically necessary or appropriate.

Orthovisc Injection series, Left Knee with ultrasound guidance.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Hyaluronic Acid Injections and, Imaging guidance for knee joint injections.

Decision rationale: The requested Orthovisc injection series of the left knee with ultrasound guidance is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has 1+ effusion synovitis and atrophy and evidence of some patellar crepitus to support osteoarthritic complaints. It was documented that the injured worker has previously undergone 2 sets of injections with more than 6 months of relief; however, the California Medical Treatment Utilization Schedule does not specifically address Orthovisc injections. The Official Disability Guidelines recommend Orthovisc injections for patients with significant symptoms of osteoarthritis. Repeat injections should be based on documentation of 6 months or greater of symptom relief and documentation of functional benefit. The clinical documentation submitted for review does not provide any evidence of significant functional benefit related to the prior injections. Additionally, the Official Disability Guidelines do not recommend fluoroscopic guidance for injection placement over anatomical landmarks. There was no documentation to support that anatomical landmarks are not sufficient for an injection placement. As such, the requested Orthovisc injection series with fluoroscopic guidance is not medically necessary or appropriate.