

<b>Case Number:</b>	CM14-0195217		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	04/23/2013
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	11/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

This case involves a male injured worker with date of injury 4/23/2013. Per primary treating physician's progress report dated 10/15/2014, the injured worker is status post left knee arthroscopy and reports continued pain without much improvement. He reports prolonged walking and standing continues to increase pain. The right shoulder remains painful with poor range of motion, and is made worse with overhead range of motion. Gait abnormality is present, due to left knee pain exacerbating bilateral foot pain with plantar pain much worse. On examination, the left knee has well healed incision, no erythema or drainage. Left knee range of motion is 5 degrees to 135 degrees, and right knee range of motion is 0 degrees to 130 degrees. Joint lines and patellar facets are tender bilaterally. Bilateral shoulder subacromial-clavicular joint tenderness to palpation is present, right worse than left. Range of motion is decreased with flexion to 170 degrees, abduction to 170 degrees, internal rotation to 80 degrees, and external rotation to 60 degrees with pain. There is positive impingement sign, positive Neer, and positive Hawkins. Bilateral hand sensation is decreased over median distribution. Flick sign is present with decreased two point discrimination. Tinnel and Durkins are positive. There is tenderness to palpation of the plantar arch and MTP. Diagnoses include bilateral knee pain and dysfunction; bilateral knee osteoarthritis, tricompartmental; bilateral knee medial meniscus tear; left knee loose bodies; status post left knee arthroscopy partial medial and lateral meniscectomy, partial synovectomy 4/24/2014; cervical spine sprain/strain; lumbar spine sprain/strain; lumbar radiculopathy; bilateral carpal tunnel syndrome; impingement syndrome bilateral shoulders; bunions, bilateral feet; and bilateral epicondylitis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) injection to the right sub-ac space with 1.5cc of Lidocaine 1% and 20mg of Kenalog:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints Page(s): 48, 204, 211.

**Decision rationale:** Per the MTUS Guidelines, injections of corticosteroids or local anesthetics or both should be reserved for patients who do not improve with more conservative therapies. Steroids can weaken tissues and predispose to reinjury. Local anesthetics can mask symptoms and inhibit long-term solutions to the patient's problem. If shoulder pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and non-steroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. Conservative care for impingement syndrome, including cortisone injections, can be carried out for at least three to six months before considering surgery. Review of medical reports, including QME dated 10/18/2013, indicates that shoulder pain has not been a complaint of the injured worker. This is despite positive exam finding of bilateral shoulder impingement sign during QME dated 10/18/2013, and reduced right shoulder range of motion in abduction, flexion, and internal rotation. It does not appear that he has any physical therapy for his shoulder. He has been treated with pain medications and other physical therapy. He also has a home exercise program which he is routinely encouraged to continue. It appears that the injured worker has had right shoulder impingement for over a year without invasive treatments. The request for one (1) injection to the right sub-ac space with 1.5cc of lidocaine 1% and 20mg of Kenalog is determined to be medically necessary.