

Case Number:	CM15-0192663		
Date Assigned:	10/06/2015	Date of Injury:	12/24/2011
Decision Date:	11/19/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	09/30/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 41 year old female who sustained an industrial injury on 12-24-11. The medical records indicate the injured worker is being treated for pain in the left shoulder joint; pes anserinus tendinitis-bursitis, right knee; chronic right knee pain; right ankle joint laxity without pain, associated with significant strain. She currently (9-17-15) complains of burning, stabbing sensation over the incision site of the left and lateral shoulder area with mild radiation down the arm towards the elbow. The pain level was 9 out of 10 with minimal benefit from Tylenol #3. Her prior pain level (7-2-15) was 7 out of 10. On physical exam (9-17-15) of the left shoulder there was tenderness over the acromioclavicular joint as well as the left lateral shoulder with only mild tenderness over the biceps tendon. Shoulder range of motion was full but produced pain to the shoulder with internal rotation and abduction. O'Brien's test, Hawkins Kennedy test and Neer's impingement test were positive. Diagnostics included MRI of the left shoulder (7-2014) showing tendinosis of the supraspinatus muscles as a result of chronic impingement, superior glenoid labral tear. Treatments to date include medications: Tylenol #3 (and multiple different pain medications per 9-17-15 note); status post left shoulder surgery, Mumford procedure as well as debridement and repair (9-26-12); acromioclavicular repair and meniscus repair (2-22-12); prior shoulder injections providing 1-2 days of reduced pain, last injection 2-2015; maximum number of physical therapy visits; per anserine injection with substantial improvement to knee pain (50%) (8-18-15). The request for authorization was not present. On 9-22-15 Utilization Review non-certified the requests for ultrasound guided left acromioclavicular joint injection; ultrasound guided right knee-Pes Anserine injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound-guided Left Arcomioclavicular (AC) Joint Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): General Approach.

Decision rationale: Per the ACOEM guidelines regarding shoulder injection: Invasive techniques have limited proven value. If 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 nonsteroidal 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. Per progress report dated 9/17/15, it was noted that the injured worker has had prior injections to the shoulder, which provided only about 1 or 2 days of reduced pain but not resolved. The medical records do not support repeat injection. The request is not medically necessary.

Ultrasound-guided Right knee/Pes Anserine Injection: Overturned

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Initial Care.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Corticosteroid injections.

Decision rationale: Per the ODG guidelines with regard to corticosteroid injections: Recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. The beneficial effect could last for 3 to 4 weeks, but is unlikely to continue beyond that. Evidence supports short-term (up to two weeks) improvement in symptoms of osteoarthritis of the knee after intra-articular corticosteroid injection. The number of injections should be limited to three. Criteria for Intra-articular glucocorticosteroid injections: Documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria, which requires knee pain and at least 5 of the following: (1) Bony enlargement; (2) Bony tenderness; (3) Crepitus (noisy, grating sound) on active motion; (4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; (5) Less than 30 minutes of morning stiffness; (6) No palpable warmth of synovium; (7) Over 50 years of age; (8) Rheumatoid factor less than 1:40 titer (agglutination method); (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm³); Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen); Pain interferes with functional activities (e.g., ambulation,

prolonged standing) and not attributed to other forms of joint disease; Intended for short-term control of symptoms to resume conservative medical management or delay TKA; Generally performed without fluoroscopic or ultrasound guidance; Absence of synovitis, presence of effusion preferred (not required); Aspiration of effusions preferred (not required); 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. The MTUS and ODG guidelines are silent on the use of pes anserine injection. I respectfully disagree with the UR physician's assertion that "No recurrent flare of symptoms is documented and no rationale is documented which would support the medical necessity for repeat pes anserine injection at this point in care" because of something noted in the most recent progress report refuting that. It is unlikely the IW would want a repeat injection unless it is hurting again. The request is medically necessary.