

Case Number:	CM15-0198275		
Date Assigned:	10/13/2015	Date of Injury:	11/07/2014
Decision Date:	12/03/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	10/08/2015

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 45 year old female, who sustained an industrial injury on 11-07-2014. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for right shoulder sprain, right hand sprain, lumbar spine sprain, and bilateral knee sprains. Medical records (03-03-2015 to 08-17-2015) indicate ongoing constant radiating right shoulder pain rated 5-9 out of 10 on a visual analog scale (VAS), constant radiating right hand pain rated 5-9 out of 10, constant radiating lumbar spine pain rated 5-9 out of 10 and associated with numbness and tingling in the legs, right leg pain rated 5-9 out of 10, and right foot pain rated 5-9 out of 10. Records also indicate no changes in activity levels or level of functioning. Per the treating physician's progress report (PR), the IW has returned to work with restrictions. The physical exam, dated 08-17-2015, revealed restricted range of motion (ROM) in the right shoulder with positive impingement signs, subacromial grinding and clicking of the right humerus, tenderness over the rotator cuff muscles, right knee flexion of 120, tenderness over the medial and lateral joint lines, positive chondromalacia patella compression and McMurray's tests, and varus of 4. Relevant treatments have included: physical therapy (PT), 7 sessions of acupuncture with some relief, work restrictions, and pain medications. The treating physician indicates that electrodiagnostic testing of the right upper extremity showed normal findings, a MRI of the right shoulder showed mild tendinosis versus a low grade partial thickness supraspinatus tear, and mild arthrosis of the acromioclavicular joint, and a MRI of the right knee showed intrasubstance degeneration and medial meniscus. The request for authorization (08-17-2015) shows that the following services were requested: ultrasound guided cortisone injection to the right shoulder

(7668), and ultrasound guided cortisone injection to the right knee (7668) with CPT code 20610. The original utilization review (09-10-2015) modified the request for ultrasound guided cortisone injection to the right shoulder (7668) (changed to 76681), and ultrasound guided cortisone injection to the right knee (7668).

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound guided cortisone injection of the right shoulder: 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 with regard to 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 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. Per the medical records submitted for review, physical exam of the right shoulder noted range of motion in degrees demonstrated flexion was 160, extension was 35, abduction was 150, adduction was 35, internal rotation was 65, and external rotation was 70. Impingement test was positive on the right. There was tenderness over the greater tuberosity of the right humerus. There was subacromial grinding and clicking of the right humerus. There was tenderness over the rotator cuff muscles on the right. However, per the guidelines, imaging guidance for shoulder injections: Glucocorticoid injection for shoulder pain has traditionally been performed guided by anatomical landmarks alone, and that is still recommended. Ultrasound guidance for shoulder joint injections is not generally necessary. As such, the request is not medically necessary.

Ultrasound guided cortisone injection of the right knee: Upheld

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

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 Intraarticular glucocorticosteroid injections include documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria. The documentation submitted for review did not contain evidence of symptomatic severe osteoarthritis per the citation above. Furthermore, per the guidelines: In the knee, conventional anatomical guidance by an experienced clinician is generally adequate. Ultrasound guidance for knee joint injections is not generally necessary. As the criteria is not met, the request is not medically necessary.