

Case Number:	CM15-0068695		
Date Assigned:	07/22/2015	Date of Injury:	06/09/2014
Decision Date:	12/21/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/10/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 61 year old female, who sustained an industrial injury on 6-09-2014. The injured worker was diagnosed as having right shoulder sprain-strain, rule out ligament tendon tear, and right knee sprain-strain, rule out ligament tear. Treatment to date has included diagnostics and medications. On 2-04-2015, the injured worker complains of right shoulder pain, rated 7 out of 10, and right knee pain, rated 6 out of 10. She reported using compound topical creams, which decreased pain up to 2 hours and "has not yet started therapy". She reported activities of daily living limitations in upper body dressing, self-care, and hygiene. Objective findings included height 62 inches and weight 259 pounds. Exam of the right shoulder noted radiating pain to the right arm, associated with a pulsating, tingling and heaviness sensation, decreased and painful range of motion, crepitation upon movement, and positive spring back test. Exam of the right knee noted pulsating and burning pain, decreased and painful range of motion, and positive McMurray's test. Magnetic resonance imaging of the right shoulder (9-29-2014) was documented to show supraspinatus tendinosis, minimal subacromial and subscapularis bursitis, osteoarthropathy of the acromioclavicular joint, and bicep tenosynovitis. She was prescribed Naproxen and Prilosec, and was provided samples of Aleve. Tried-failed medications were not specified. Work status was total temporary disability. The treatment plan included ultrasound of the right knee and right shoulder, magnetic resonance imaging of the right knee and right shoulder, injection (intermediate-major joint or bursa) to the right knee, injection (intermediate-major joint or bursa) to the right shoulder, compound

transdermal cream: Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base, and Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2% in cream base.

IMR ISSUES, DECISIONS AND RATIONALES

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

US right knee: 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 Ultrasonic diagnostic.

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, Ultrasound Diagnostic.

Decision rationale: The ODG Knee and Leg Chapter states the following regarding diagnostic ultrasound: "Ultrasound guidance for knee joint injections is not generally either recommended or not recommended, but it should not be a substitute for lack of clinical skill or experience, so injections can be done by less qualified personnel. Some areas are difficult to hit with an injection, such as SI joints or pancreatic ducts, but knee injections should not generally require ultrasound guidance. See also Corticosteroid injections." In the case of this worker, there is no clear-cut documentation of why ultrasound was utilized in this case. Guidelines specify that knee injections do not typically require ultrasound guidance and therefore without any identification of an extenuating circumstance, this request is not medically necessary.

US right 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, Shoulder Ultrasonic diagnostic.

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

Decision rationale: Regarding the request for ultrasound studies of the right shoulder, California MTUS cites that ultrasonography for evaluation of rotator cuff is not recommended. Within the documentation available for review, there is no documentation of subjective/objective findings consistent with a condition/diagnosis for which ultrasound is supported given the lack of support for its use in the evaluation of the rotator cuff. In the absence of such documentation, the currently requested ultrasound studies of the right shoulder is not medically necessary.

Injection (intermediate/major joint or bursa) to right knee: 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.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Activity Alteration, Summary, Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Corticosteroid injections.

Decision rationale: Regarding the request for a steroid injection of the knee, ACOEM Chapter 13 specifies that aspiration and corticosteroid injections are options for knee pain. Table 13-6 on page 346 specifies that "repeat aspirations or corticosteroid injections" are optional. Further specification of the conditions in which steroid injection are warranted are found in the ODG. The ODG states that intra-articular corticosteroid injections are 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. The criteria for intra-articular glucocorticosteroid injections, according to the American College of Rheumatology (ACR), states that there has to be documentation of 1) severe osteoarthritis of the knee with knee pain, 2) not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen); 3) pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease ;4) intended for short-term control of symptoms to resume conservative medical management or delay TKA. Guidelines go on to state that 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. Within the documentation available for review, there is not documentation that the patient has failed conservative treatment such as physical therapy or NSAID treatment. Additionally, there is no documentation of an x-ray identifying osteoarthritis of the knee in question. As such, the currently requested knee steroid injection is not medically necessary.

Injection (intermediate/major joint or bursa) right 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, Shoulder.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Injection Topic.

Decision rationale: Regarding the request for shoulder injection, the Shoulder Complaints Chapter of ACOEM on page 204 states the following: "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." Further guidelines include the ODG, which 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. Within the documentation available for review, the recent conservative care of the shoulder is not apparent. The progress note dated 2/4/15 indicated that the patient has crepitus on exam, reduced ROM with extension, and positive drop arm test. However, there is no documentation of failure of conservative treatment prior to starting steroid injection. Given this lack of documentation, the currently requested shoulder injection is not medically necessary.

Compound transdermal cream: Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: With regard to this request for a topical compounded cream that contains gabapentin as a component, the CPMTG does not recommend topical gabapentin. On page 113 of the Chronic Pain Medical Treatment Guidelines, the following is stated: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." The guidelines further state that if one drug or drug class of a compounded formulation is not recommended, then the entire compounded formulation is not recommended. Therefore, the topical gabapentin component is not recommended, and the entire formulation is not medically necessary.

Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2% in cream base: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding this request, one of the components requested is topical baclofen. Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 113 of 127 state the following: "Topical Baclofen: Not recommended. There is currently one Phase III study of Baclofen-Amitriptyline- Ketamine gel in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer-reviewed literature to support the use of topical baclofen." Given these guidelines, the topical baclofen is not medically necessary. Since any formulation must have all components as recommended in order for the formulation to be medically necessary, this request is not medically necessary.

MRI right 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, Shoulder.

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

Decision rationale: Regarding the request for repeat shoulder MRI, ACOEM Practice Guidelines do not have specific guidelines on when a repeat study is warranted. In general, lumbar MRI is recommended when there are unequivocal objective findings that identify specific nerve compromise on the neurologic examination in patients who do not respond to treatment and would consider surgery an option. The Official Disability Guidelines state that repeat MRIs should be reserved for cases in which a significant change in pathology has occurred. Within the documentation available for review, the patient has had a previous MRI on 9/14. A review of the progress note since that time does not indicate any acute intervening injury or sudden change in pathology. Given this, the current request is not medically necessary.

MRI right knee: Overturned

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

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

Decision rationale: Regarding the request for MRI right knee, CA MTUS and ACOEM note that, in absence of red flags (such as fracture/dislocation, infection, or neurologic/vascular compromise), diagnostic testing is not generally helpful in the first 4-6 weeks. After 4-6 weeks, if there is the presence of locking, catching, or objective evidence of ligament injury on physical exam, MRI is recommended. Within the medical information made available for review, there is documentation of ongoing knee pain with a positive McMurray's test, which is evidence of catching on physical examination testing suggestive of meniscal injury. The patient also has knee tenderness and decreased range of motion. In light of the above, the currently requested MRI is medically necessary.