

Case Number:	CM15-0139765		
Date Assigned:	07/29/2015	Date of Injury:	12/16/2007
Decision Date:	09/17/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/20/2015

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: Emergency Medicine

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 62 year old female, who sustained an industrial injury on 12-16-07. Initial complaints were not reviewed. The injured worker was diagnosed as having lumbar spondylosis; lumbar degenerative disc disease; lumbar disc without myelopathy; adhesive capsulitis bilateral shoulders; bilateral carpal tunnel syndrome; cervical radiculopathy; bilateral knee meniscal tear; bilateral hip osteoarthritis; depression; anxiety; chronic lower back pain; postlaminectomy syndrome lumbar; sacroiliac joint arthropathy; status post bilateral total hip replacements. Treatment to date has included physical therapy; cognitive behavioral therapy; medications. Diagnostics studies included MRI right shoulder (4-1-13). Currently, the PR-2 notes dated 5-28-15 indicated the injured worker returns to the office for multiple orthopedic issues. She reports her left shoulder pain is "killing her". Her right knee pain is consistent. She also has ongoing right shoulder ache. At the last visit she has a cortisone injection to the left shoulder which helped but the pain is still persistent in the left shoulder as well as stiffness. She understands she would benefit from a total shoulder replacement of the left shoulder. She reports doing home exercise program on her own using light weights for strength building. On physical examination, the provider documents tenderness to palpation of the right knee medial joint. Motor strength is noted at 5+ in the quadriceps and hamstring. Active range of motion of the left shoulder is 90 degrees in abduction, 110 degrees in forward flexion and internal and external rotation strength is 5+. He notes her surgical history of left shoulder joint degenerative changes, and right knee joint degenerative changes and right shoulder pain. The provider administered a right knee cortisone injection on this date. She understands she would benefit from a left shoulder replacement. She informs the provider she is moving but will commute

to his office for treatment. The provider is requesting authorization of retrospective right knee cortisone injection for date of service 5-28-15. A letter of appeal dated 8/8/15 was reviewed. It only noted that the injection was for pain and that prior injections were approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: right knee cortisone injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee: Corticosteroid injections.

Decision rationale: MTUS ACOEM guidelines generally do not recommend knee injections. However, Official Disability Guidelines were reviewed for details criteria. ODG recommend knee injections under certain criteria and short-term use only. ODG recommend injections only with documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria. Provided documentation fails to meet this criteria. Except for short-term pain control, there is no other rationale for injection documented which is not an appropriate justification as per guidelines. Knee injection is not medically necessary.