

<b>Case Number:</b>	CM15-0184261		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	03/28/2014
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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: Massachusetts

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 45 year old male, who sustained an industrial injury on 3-28-14. The injured worker is being treated for right and left wrist sprains, cervical sprain, lumbosacral sprain, lumbosacral scoliosis, right and left knee sprains, right and left ankle sprains and right and left heel sprains. (MRI) magnetic resonance imaging of right shoulder performed on 4-13-15 revealed moderate impingement syndrome, tendinosis and edema of rotator cuff with a partial tear in region of the supraspinatus tendon and fluid in the sub deltoid space. Treatment to date has included physical therapy, acupuncture and activity modifications. On 7-7-15, the injured worker complains of constant right wrist pain, left wrist pain, constant right shoulder pain without radiation (pain is relieved with stopping activities), left shoulder pain which is constant without radiation, constant neck pain relieved with acupuncture, constant low back pain without radiation and right knee pain which is constant without radiation; he notes the knee has locked twice in the past 30 days and left knee pain with swelling once in 30 days and limited range of motion. He is temporarily partially disabled. Physical exam of bilateral shoulders revealed low back pulling on right and left shoulder motion and low back pulling on right and left knee motion without effusion, tenderness or crepitus. On 9-8-15 request for 1 right shoulder injection and 1 knee injection was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One right shoulder injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder 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) Shoulder (Acute & Chronic), Steroid injections.

**Decision rationale:** The claimant has a history of a cumulative trauma work injury with date of injury in March 2014. An MRI of the right knee in April 2015 showed findings of a medial meniscus tear and partial posterior cruciate ligament tear. An MRI of the right shoulder showed findings of moderate rotator cuff impingement with a partial supraspinatus tear. He continues to be treated for chronic widespread pain including right shoulder and right knee pain. He was seen for an AME on 07/07/15. X-rays of the right knee were normal. There was no right knee tenderness, crepitus, or joint effusion. Shoulder impingement testing was negative. When seen by the requesting provider, injections were requested for that right knee and for the right shoulder. A corticosteroid injection for the shoulder can be recommended. Criteria include a diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems not controlled adequately by recommended conservative. In this case, the type of injection being requested is not specified. Whether a subacromial or other injection is being requested is unknown. In July 2015 shoulder impingement testing was negative. The request cannot be accepted as being medically necessary.

**One knee (unspecified) injection:** 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 (Acute & Chronic), Corticosteroid injections.

**Decision rationale:** The claimant has a history of a cumulative trauma work injury with date of injury in March 2014. An MRI of the right knee in April 2015 showed findings of a medial meniscus tear and partial posterior cruciate ligament tear. An MRI of the right shoulder showed findings of moderate rotator cuff impingement with a partial supraspinatus tear. He continues to be treated for chronic widespread pain including right shoulder and right knee pain. He was seen for an AME on 07/07/15. X-rays of the right knee were normal. There was no right knee tenderness, crepitus, or joint effusion. Shoulder impingement testing was negative. When seen by the requesting provider, injections were requested for that right knee and for the right shoulder. Criteria for an intra-articular knee injection include documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria and symptoms not controlled adequately by recommended conservative treatments such as exercise, acetaminophen, and NSAID medication. In this case, there is no diagnosis of severe osteoarthritis either by x-ray or fulfilling the ACR criteria. The requested intra-articular knee injection is not medically necessary.

