

<b>Case Number:</b>	CM15-0096995		
<b>Date Assigned:</b>	05/27/2015	<b>Date of Injury:</b>	12/17/2001
<b>Decision Date:</b>	06/26/2015	<b>UR Denial Date:</b>	05/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2015

### 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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This then said 54-year-old female, sustained an industrial injury on 12/17/2001. According to a progress report dated 04/23/2015, the injured worker had coverage for neck, bilateral brachial plexus, left shoulder, left elbow, low back and costochondritis. She also had injuries to the left knee which was causing pain in the right knee as well as her low back. She had been working in pain and had missed previously several days because of flare-up. The provider filled out family medical leave. She used a cane and topical patches and lotions. She was still having headaches secondary to neck pain. Objective findings included tenderness along the cervical paraspinal muscles. She had pain along the left shoulder, rotator cuff and biceps tendon as well as pain along the low back, paraspinal muscles as well as both knees. She had difficulty standing on toes and heels. Diagnoses included discogenic cervical condition with facet inflammation, shoulder girdle involvement and headaches, brachial plexus neuritis on the left upper extremity with flare-ups from time to time, rotator cuff strain on the left with MRI showing ligament tear not the rotator cuff tear in the past, epicondylitis more laterally than medially on the left and discogenic lumbar condition with radicular component down the lower extremities. Nerve studies 10 years ago were negative. MRI showed disc disease at L4-L5. Treatment plan included Voltaren gel 1%, Lidoderm patch 5%, hinged knee brace for the left knee, cortisone injection to the left knee and physical therapy 12 sessions for the left shoulder, neck and low back. The injured worker was currently working. Currently under review is the request for hinged knee orthosis for the left knee and a cortisone injection to the left knee.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Hinged knee orthosis for left knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

**Decision rationale:** EM states "A brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program." The patient is not diagnosed with patellar instability, anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL) instability. The patient is currently working and the records are not stating that the patient will be stressing the knee by climbing or carrying a load. As such, the request for Hinged knee orthosis for left knee is not medically necessary.

### **Cortisone injection to left knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 345-347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Corticosteroid injections.

**Decision rationale:** ACOEM states that for aspirations and injections of the knee that "Panel interpretation of information not meeting inclusion criteria for research-based evidence." It is a D recommendation. ODG states "Recommended for short-term use only." The ODG criteria are listed below. Criteria for Intraarticular 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/mm<sup>3</sup>); 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 treating physician has not provided documentation to meet at least 5 of the above criteria to justify a knee injection at this time. As such, the request for cortisone injection to left knee is not medically necessary.