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| <b>Case Number:</b>   | CM13-0051836 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 05/19/2012 |
| <b>Decision Date:</b> | 03/17/2014   | <b>UR Denial Date:</b>       | 10/28/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/14/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 45-year-old female who reported an injury on 05/09/2012. The patient is diagnosed with lumbar spine strain/sprain with bilateral lower extremity radiculitis, right hip greater trochanteric bursitis, right knee sprain, and right ankle sprain. The patient was seen by [REDACTED] on 11/22/2013. The patient reported pain, weakness and swelling of the right knee and right hip. Physical examination of the right knee revealed diffuse swelling and tenderness to palpation over the medial and lateral joint lines. Patellar compression test and grind test were positive and there was decreased range of motion. Treatment recommendations included weight-bearing x-rays of the right knee, continuation of current medications and exercise program, a Bionicare knee system, ultrasound-guided right knee Synvisc injections, and an ultrasound-guided right hip greater trochanteric injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Bionicare knee system to the right knee qty 1:**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Bionicare® knee device.

**Decision rationale:** Official Disability Guidelines state Bionicare knee device is recommended as an option for patients in a therapeutic exercise program for osteoarthritis of the knee, who may be candidates for a total knee arthroplasty but want to defer surgery. As per the documentation submitted, the patient is diagnosed with a right knee sprain. There is no documentation of osteoarthritis. There is also no evidence of this patient's active participation in a therapeutic exercise program to be used in conjunction the Bionicare knee system. The medical necessity has not been established. Therefore, the request is non-certified.

**Three ultrasound-guided Synvisc injections to the right knee 2ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Hyaluronic acid injections.

**Decision rationale:** Official Disability Guidelines state criteria for hyaluronic acid injections includes patients who experience significantly symptomatic osteoarthritis and have not responded adequately to recommended conservative non-pharmacologic and pharmacologic treatment for at least 3 months. As per the documentation submitted, there is no evidence of symptomatic osteoarthritis of the knee. The patient does not demonstrate bony enlargement, crepitus, less than 30 minutes of morning stiffness, or no palpable warmth of synovium. There is also no evidence of a failure to adequately respond to aspiration and injections of intra-articular steroids. There is no documentation of a recent failure to respond to conservative treatment including exercise and physical therapy. Based on the clinical information received, the request is non-certified.

**One ultrasound-guided greater trochanteric bursitis injection to the right hip:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Trochanteric bursitis injections and Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Ultrasound (Sonography).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Trochanteric bursitis injections.

**Decision rationale:** Official Disability Guidelines state trochanteric bursitis injections are recommended. As per the documentation submitted, there was no evidence of a physical

examination of bilateral hips on the requesting date of 11/22/2013. There is no documentation of a significant musculoskeletal deficit with regard to bilateral hips. There is also no documentation of a recent failure to respond to more conservative treatment prior to the request for an injection. Based on the clinical information received, the request is non-certified.