

<b>Case Number:</b>	CM14-0008935		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	05/26/2005
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	09/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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/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 58-year-old male who has submitted a claim for degenerative medial meniscal tear with underlying left knee osteoarthritis and left medial femoral condyle osteochondral defect associated from an industrial injury date of May 26, 2005. Medical records from 2013 were reviewed, the latest of which dated August 21, 2013 showing that the patient's primary complaint is pain. He denies any clicking, catching or locking. He has been using Lidoderm patches with mild relief. On physical examination, there is tenderness noted along the medial joint line with some crepitus but no click or clunk with McMurray's. He has a mild effusion. An x-ray of the left knee dated May 13, 2005 revealed mild osteoarthritis/osteopenia with beginning joint space narrowing. MRI of the left knee dated September 2, 2005 revealed small osteochondral lesion in medial femoral condyle, unstable. Nonspecific bone marrow edema/contusion posterior medial and lateral femoral condyle. Mild sprain versus partial ACL tear. Minimal joint effusion. An x-ray of the left knee dated July 5, 2011 revealed mild to moderate osteoarthritis. Chronic osteochondral injury at medial femoral condyle with articular contour abnormality. MRI of the left knee dated April 10, 2013 revealed linear signal in the body of the medial meniscus and attenuation of the meniscus consistent with prior partial meniscectomy. Treatment to date has included left knee arthroscopic debridement and microfracture of the osteochondral defect (2005), physical therapy, and medications which include Lidoderm patch, Celebrex, Tramadol, Cyclobenzaprine, Etodolac and Mobic. Utilization review from September 25, 2013 denied the retrospective request for 2CC depo-medrol and 3cc Lidocaine and Marcaine Injection to the left knee (DOS 8/21/13) because there was no objective evidence of bony enlargement and palpable warmth of the synovium; there was no documentation of relevant laboratory procedure to support the necessity of the requested procedure; and there was no evidence of failure with recommended conservative care including physical therapy and medications.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **RETROSPECTIVE (DOS 8/21/13): 2CC DEPO-MEDROL AND 3CC LIDOCAINE AND MARCAINE INJECTION TO THE LEFT KNEE:** Upheld

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

**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, Corticosteroid injections.

**Decision rationale:** The California MTUS does not address the topic on corticosteroid injections. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Divisions of Workers Compensation, the Official Disability Guidelines was used instead. ODG recommends corticosteroid injections for short-term use only. It 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. It is recommended for 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: bony enlargement; bony tenderness; crepitus (noisy, grating sound) on active motion; erythrocyte sedimentation rate (ESR) less than 40 mm/hr; less than 30 minutes of morning stiffness; no palpable warmth of synovium; over 50 years of age; Rheumatoid factor less than 1:40 titer (agglutination method); synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm<sup>3</sup>). In this case, corticosteroid injection was recommended for the left knee pain. However, the patient does not satisfy the criteria for symptomatic severe osteoarthritis. Also, there is no documentation of failure of conservative treatments. The medical necessity for corticosteroid injection was not established. Therefore, the retrospective request for 2cc depo-medrol and 3cc Lidocaine and marcaine injection to the left knee is not medically necessary.