

<b>Case Number:</b>	CM14-0161150		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	07/18/2011
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 Emergency Medicine 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 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 with reported date of injury on 7/18/2011. Mechanism of injury was not provided for review. Patient has a diagnosis of old bucket handle tear of medial meniscus and tear medial cartilage or meniscus of knee. Patient is post R lateral meniscectomy and femoral chondroplasty. Medical reports reviewed. Last report available until 9/16/14. Most of the progress notes are hand written and are poorly legible due to poor hand writing and very brief. If words are not clear and legible, for appropriate independent medical review, I will not guess or assume what the documenter was attempting to write due to significant risk of errors. Not a single legible sentence can be made from the last note from 9/16/14. Only a few individual words are legible. Even objective exam is not legible. In that note it mentions "awaiting cont <not legible> re PT", "Discussed Hyalgan as means of decrease R knee pain. Request Hyalgan injections R knee (3)". Note from 4/15 and 4/22/14 mentions R knee Hyalgan injections. Most useful information was gleaned from UR reports. Reports reveal certification of several physical therapy sessions. At least 16 sessions was certified. No imaging studies were provided for review. No medications were noted in any note. It is not clear what medications is taking. Independent Medical Review is for Hyalgan injection of R knee x3. Prior UR on 9/25/14 recommended non-certification.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hyalgan injection right knee x3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Hyaluronic Acid injections

**Decision rationale:** The MTUS Chronic pain or ACOEM guidelines do not adequately have any specific sections that deal with this topic. Official Disability Guidelines(ODG) recommend it as an option in osteoarthritis in situations where conservative treatment has failed to manage the pain and to delay total knee replacement. The benefits are transient and moderate at best. It is recommended for severe arthritis and to prevent surgery such as total knee replacement. Basic criteria are: 1) Severe osteoarthritis: Fails criteria. The provider has failed to provide any imaging or any documentation as to severity of arthritic disease. Patient has prior documented meniscectomy and surgery but the provider's poor hand writing and poor documentation does not support this criteria. 2) Failure to adequately respond to steroid injection. Fails criteria. Pt has had any documented steroid injections in the past. Documentation does not properly document pain control and response. 3) Failure of pharmacologic and conservative therapy. Documentation fails to meet this criteria. Provider has failed to provide documentation of medications and prior pharmacologic therapy. There is no noted response to physical therapy, home exercise or any conservative therapy. 4) Documented improvement from prior injections: Must document significant improvement lasting at least 6months. Pt had injections done 5months prior and there is no appropriate documentation of response. Patient fails multiple criteria to recommend Hyalgan injection. Therefore the request for Hyalgan Injection is not medically necessary.