

<b>Case Number:</b>	CM14-0092248		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	02/11/1999
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	05/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2014

### 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 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 injured worker is a 63 year old male who sustained an injury to his right knee on 02/11/99. Mechanism of injury was not documented. Clinical note dated 02/19/14 reported that the injured worker was status post painful hardware removal of the right knee. The injured worker complained of pain in the right knee with range of motion and climbing up and down stairs. This got progressively worse over the past couple of months and the injured worker felt that his knee was unstable. Clinical note dated 03/19/14 reported that the injured worker was having balance issues because of his right knee pain. There was no pain with rest, positive pain with range of motion and weight bearing. Physical examination of the right knee noted range of motion 0-110 degrees, limited by pain; unstable in varus/valgus testing at 0 and 30 degrees; positive anterior/posterior drawer testing; progressively getting worse. There was no imaging study provided for review. The injured worker was diagnosed with knee joint replacement status post, primary localized osteoarthritis, unspecified synovitis/tenosynovitis and trochanteric bursitis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Kenalog injection under ultrasound guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip & Pelvis Procedure Summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Corticosteroid injections

**Decision rationale:** The request for left Kenalog injection under ultrasound guidance is not medically necessary. Previous request was denied on the basis that the Official Disability Guidelines state that intra-articular steroid hip injections are not recommended in early hip osteoarthritis. In this case, the injured worker complained of left hip pain. However, it is unclear whether the injured worker has previously trialed and failed more conservative treatment for the left hip. It was unclear if the Kenalog injection was requested for the left hip or the knee. In either case, there must be documentation that the pain has not been adequately controlled by recommended conservative treatment (exercise, NSAIDs, or acetaminophen). There were no physical therapy notes provided for review indicating the amount of physical therapy visits that the patient had completed to date or the injured worker's response to any previous conservative treatment. There was no indication that the injured worker was actively participating in a home exercise program. Given this, the request for left Kenalog injection under ultrasound guidance is not indicated as medically necessary.

**Right knee hinged brace purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee and Leg Procedure Summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and leg chapter, Unloader braces for the knee

**Decision rationale:** The request for right knee hinged brace purchase is not medically necessary. Previous request was denied on the basis that in this case, the injured worker complained of right knee pain, status post right knee total arthroplasty, and hardware removal. Plain radiographs of the knee did not show any instability. Pending results of the authorized referral to an arthroplasty surgeon, the request was not deemed as medically appropriate. After reviewing the submitted clinical documentation, there was no significant objective clinical information provided that would support reverse of the previous adverse determination. Given this, the request for right knee hinged brace purchase is not indicated as medically necessary.