

Case Number:	CM14-0187464		
Date Assigned:	11/17/2014	Date of Injury:	05/05/2006
Decision Date:	01/06/2015	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	11/10/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 a 52-year-old with a reported date of injury of 05/04/2006. The patient has the diagnoses of left knee arthrosis, left knee pes anserinus bursitis, cervical thoracic strain, right shoulder pain status post arthroscopic subacromial decompression, left shoulder impingement syndrome, status post right elbow lateral epicondylar release, bilateral hand and wrist sprain/strain, right occipital neuralgia, status post left knee arthroscopy and lumbosacral strain. Per the progress notes provided for review from the requesting physician dated 04/15/2014, the patient had complaints of continued constant left knee pain. The physical exam noted left knee swelling, tenderness to palpation at the medial joint line and at the pes bursa. The treatment plan recommendations included left knee injection, unloader brace and continued medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro 1cc Kenalog Injection with 7cc of Lidocaine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2014 Knee & Leg, Corticosteroid Injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339.

Decision rationale: The ACOEM chapter on Knee Complaints and invasive techniques for treatment states: Invasive techniques, such as needle aspiration of effusions or prepatellar bursal fluid and cortisone injections, are not routinely indicated. Knee aspirations carry inherent risks of subsequent intra-articular infection. - A reddened, hot, swollen area may be a sign of cellulitis or infected prepatellar bursitis; thus, aspirating the joint through such an area is not recommended because microorganisms may be introduced into a previously sterile joint space. - If a patient has severe pain with motion, septic effusion of the knee joint is a possibility, and referral for aspiration, Gram stain, culture, sensitivity, and possibly lavage may be indicated. Initial atraumatic effusions without signs of infection may be aspirated for diagnostic purposes. - There is a high rate of recurrence of effusions after aspiration, but the procedure may be worthwhile in cases of large effusions or if there is a question of infection in the bursa. - Patients with recurrent effusions who have a history of gout or pseudo-gout may need aspiration to rule out infection, but more likely will need it only for comfort, if at all. Osteoarthritis can present with effusions, but findings of crepitus, palpable osteophytes, and history of chronic symptoms are usually sufficient to make the differential diagnosis. - Swelling and sponginess anterior to the patella is consistent with a diagnosis of prepatellar bursitis. The ACOEM does not routinely recommend cortisone injection of the knee. Per the progress reports the patient has a history of multiple left knee injections in the past with variable results. Given this documentation and the ACOEM recommendations, the request is considered not medically necessary.