

<b>Case Number:</b>	CM15-0100168		
<b>Date Assigned:</b>	06/02/2015	<b>Date of Injury:</b>	03/30/2012
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

### 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 62 year old female who reported an industrial injury on 3/30/2012. Her diagnoses, and/or impressions, are noted to include: right knee sprain/strain; bilateral knee medial and lateral tears with tendonopathy, internal derangement and pain; internal derangement, torn medial meniscus and medial compartment arthritis of the right knee; and status-post bilateral knee arthroscopy surgeries. Recent Sudoscan-Sudomotor function assessment and diagnostic report was noted on 2/9/2015, which noted normal symmetry of both hands and feet. No current electrodiagnostic studies or imaging studies of the knees are noted. Her treatments have included arthroscopic surgery with total meniscectomy and chondroplasty of the right knee on 10/23/2014; arthroscopic left knee surgery; therapy for the bilateral knees (12/2014 - 1/2015); medication management with urine toxicology screenings; and rest from work before returning to modified work duties. The progress notes reported continued complaints of right knee pain. The objective findings were noted to include pain, joint swelling, stiffness, numbness/tingling, and decreased range-of-motion in the right knee. The physician's requests for treatments were noted to include a right knee injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Knee Injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee injections.

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

**Decision rationale:** The ACOEM chapter on knee complaints and injections 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 intraarticular 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 pseudogout 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. Criteria have not been met in the documentation submitted for review. Therefore the request is not medically necessary.