

Case Number:	CM15-0169111		
Date Assigned:	09/09/2015	Date of Injury:	09/23/2012
Decision Date:	10/07/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	08/27/2015

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 36-year-old female, who sustained an industrial injury on 09-23-2012 resulting in pain or injury to the left knee. A review of the medical records indicates that the injured worker is undergoing treatment for depression, tension headaches, and insomnia, left knee pain, low back pain, shoulder pain and neck pain. Medical records (08-04-2015 to 08-17-2015) indicate ongoing left knee pain with locking and occasional buckling. Records also indicate no changes in activities of daily living, but did indicate an increase in pain level during the exams. Per the treating physician's progress report, the injured worker was able to return to work with restrictions; however, it was not noted whether the injured worker was working or not. The physical exams, dated 08-04-2015 and 08-17-2015, revealed no changes in range of motion of the left knee, tenderness upon palpation, physical exam of the left knee, motor strength or sensory exam. Relevant treatments have included 10-13 sessions of physical therapy reported to be somewhat helpful, and medications with short-term relief. The treating physician indicates that a MRI of the left knee was completed after the initial injury date and was reportedly normal. The request for authorization (08-17-2015) shows that the following procedure w requested bursa, joint and tendon intra-articular injection to the left knee. The original utilization review (08-24-2015) denied the request for bursa, joint and tendon intra-articular injection to the left knee due to the absence of documented results from the first authorized injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bursa/Joint/Tendon Intraarticular Injection to the Left Knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Initial Care.

Decision rationale: The ACOEM chapter on knee complaints 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. The review of the medical records provided do not show criteria met as cited above and thus the request is not medically necessary.