

<b>Case Number:</b>	CM15-0181358		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	04/24/2014
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 24-year-old male, who sustained an industrial injury on April 24, 2014. He reported left knee pain. The injured worker was diagnosed as having derangement of lateral meniscus. Treatment to date has included diagnostic studies, radiographic imaging, medications and physical therapy. Currently, the injured worker continues to report continuous sharp left knee pain with associated popping and giving out. The injured worker reported an industrial injury in 2014, resulting in the above noted pain. He was without complete resolution of the pain. Evaluation on June 25, 2015, revealed continued left knee pain as well as low back pain. He rated his pain at 6-9 on a 1-10 scale with 10 being the worst. He noted depression and anxiety secondary to continued pain and noted it was difficult to perform activities of daily living and personal hygiene. Radiographic imaging of the left knee on July 23, 2015, revealed a normal study. Evaluation on August 12, 2015, revealed continued pain as noted. It was noted NSAIDs caused stomach upset. Assessment of the left knee revealed no deformities or misalignments, no swelling or redness, no temperature changes and boney landmarks in correct anatomical position. The range of motion was noted as not restricted. Stability testing of the knee was noted as normal. It was noted he had tender medial and lateral joints. The RFA included a request for Cortisone injection to the left knee, quantity of one and was non-certified on the utilization review (UR) on August 18, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cortisone injection to the left knee, quantity of one:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter/Corticosteroid injections Section.

**Decision rationale:** MTUS guidelines state that 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. Per the ODG cortisone injection of the knee are recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. The beneficial effect could last for 3 to 4 weeks, but is unlikely to continue beyond that. Evidence supports short-term (up to two weeks) improvement in symptoms of osteoarthritis of the knee after intra-articular corticosteroid injection. The number of injections should be limited to three. The short-term benefit of intra-articular (IA) corticosteroids in treatment of knee osteoarthritis is well established, and few side effects have been reported. Longer-term benefits have not been confirmed. Comparisons of IA corticosteroids showed triamcinolone hexacetonide was superior to betamethasone for number of patients reporting pain reduction up to four weeks post injection. The response to hyaluronan/hylan products appears more durable, compared to corticosteroids. There must be documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria, which requires knee pain and at least 5 of the following: (1) Bony enlargement; (2) Bony tenderness; (3) Crepitus (noisy, grating sound) on active motion; (4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; (5) Less than 30 minutes of morning stiffness; (6) No palpable warmth of synovium; (7) Over 50 years of age; (8) Rheumatoid factor less than 1:40 titer (agglutination method); (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm<sup>3</sup>). Additional criteria to support use of IA corticosteroid use include: (1) Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen); (2) Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; (3) Intended for short-term control of symptoms to resume conservative medical management or delay TKA; (4) Generally performed without fluoroscopic or ultrasound guidance; (5) Absence of synovitis, presence of effusion preferred (not required); (6) Aspiration of effusions preferred (not required); (7) Only one injection should be scheduled to start, rather than a series of three; (8) A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; (9) With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; (10) The number of injections should be limited to three. In this case, a recent assessment of the left knee revealed no deformities, no swelling or redness, and no temperature changes. Range of motion was noted as not restricted. Stability testing of the knee was noted as normal. Radiographic imaging of the left knee on July 23, 2015, revealed a normal study. There is no evidence of knee osteoarthritis in the available documentation. Therefore, the request for cortisone injection to the left knee, quantity of one is determined to not be medically necessary.

