

Case Number:	CM15-0184832		
Date Assigned:	09/25/2015	Date of Injury:	11/26/2004
Decision Date:	11/06/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/21/2015

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 41-year-old female, who sustained an industrial injury on November 26, 2004, incurring upper, mid and lower back injuries and bilateral hand and right knee injuries. She was diagnosed with a cervical, thoracic and lumbar sprain, cervical degenerative disc disease, thoracic degenerative disc disease, lumbar degenerative disc disease, bilateral carpal tunnel syndrome and a right knee sprain. She had a history of Fibromyalgia. Treatment included pain management, neuropathic medications, proton pump inhibitor, sleep aides, anti-inflammatory drugs, epidural steroid injection, physical therapy and home exercise program, aqua therapy two times a week for six weeks and a Marcaine injection to the right knee with some relief of pain. Currently, the injured worker complained of right knee pain with tenderness and pain on range of motion. There was crepitus noted of the right patella. She noted increased knee pain aggravated by activities, bending, prolonged sitting, standing, twisting and walking. Magnetic Resonance Imaging of the right knee revealed joint effusion, patellar fluid with thickening of the synovium. The treatment plan that was requested for authorization on September 21, 2015, included an injection with Tramadol-Celestone-Marcaine to the right knee given on July 28, 2015; and a request for supplies and administration. On September 14, 2015, a request for a right knee injection and supplies and administration of the injection was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for injection with Tramadol/Celestone/Marcaine to the right knee (DOS: 07/28/15): Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Procedure Summary.

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. 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. This injured worker is chronically injured and the short term benefit from a corticosteroid injection is not considered a medically necessary procedure in her management. The retrospective request for injection with Tramadol/Celestone/Marcaine to the right knee (DOS: 07/28/15) is determined to not be medically necessary.

Retrospective request for supplies and administration (DOS: 07/28/15): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. 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. This injured worker is chronically injured and the short term benefit from a corticosteroid injection is not considered a medically necessary procedure in her management. The supplies for this procedure are therefore not considered necessary. The retrospective request for supplies and administration (DOS: 07/28/15) is determined to not be medically necessary.