

<b>Case Number:</b>	CM15-0207233		
<b>Date Assigned:</b>	10/26/2015	<b>Date of Injury:</b>	03/20/2006
<b>Decision Date:</b>	12/07/2015	<b>UR Denial Date:</b>	10/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2015

### 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, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 57 year old male, who sustained an industrial injury on 03-20-2006. The injured worker was diagnosed as having other tear of medial meniscus, current injury, right knee - subsequent encounter. On medical records dated 06-24-2015 and 10-02-2015, the subjective complaints were noted as knee pain 5 out of 10 at rest, and 7 out of 10 with stairs and pressure on knee cap, grinding sensation under knee cap was noted. Objective findings were noted as right knee - tenderness to palpation medial joint line and with patellofemoral grind, range of motion was noted as ok as well as strength. Treatments to date included physical therapy and medication. Per documentation x-ray revealed appropriate joint space. Current medications were listed as Percocet and Elavil and Neurontin. The Utilization Review (UR) was dated 10-13-2015. A Request for Authorization was dated 10-05-2015. The UR submitted for this medical review indicated that the request for Ultrasound Guided Injection Right Knee was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultrasound Guided Injection Right Knee: Upheld**

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

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

**Decision rationale:** According to ODG knee / Corticosteroid injections: "Criteria for Intraarticular glucocorticosteroid injections: 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>); Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen); Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; Intended for short-term control of symptoms to resume conservative medical management or delay TKA; Generally performed without fluoroscopic or ultrasound guidance; Absence of synovitis, presence of effusion preferred (not required); Aspiration of effusions preferred (not required); Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three." In this patient the ODG criteria have not been met and thus the request is not medically necessary.