

Case Number:	CM15-0115105		
Date Assigned:	06/23/2015	Date of Injury:	02/08/2008
Decision Date:	07/23/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/15/2015

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: 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 56 year old female, who sustained an industrial injury on 2/8/08. She has complained of initial right knee pain after injury at work. The diagnoses have included pain in joint of lower leg, post traumatic arthritis of the right knee, right medial meniscal injury with pes anserine tendinosis, cervical disc injury and right rotator cuff injury. Treatment to date has included medications, activity modifications, diagnostics, orthopedic consult, medial branch blocks, surgery, physical therapy, Cognitive Behavioral Therapy (CBT) and home exercise program (HEP). Currently, as per the physician progress note dated 4/24/15, the injured worker states that her orthotic was recently replaced, however it tends to slide down her leg. She has not had it resized to be re-fitted. The injured worker is requesting a right knee injection, as her knee brace has been problematic due to walking without stability. She is also feeling depressed and frustrated. The diagnostic testing that was performed included x-ray of the right knee dated 7/10/09 reveals a small suprapatellar effusion is suspected. Magnetic Resonance Imaging (MRI) of the right knee dated 2/26/08 revealed complex tear in the posterior horn medial meniscus, moderately large joint effusion and thickened proximal posterior cruciate ligament raises question for previous sprain. The exam of the right knee reveals that she ambulates with antalgic gait, there is moderate pain present over the lateral more than the medial joint line, the patellar compression sign is positive with tenderness noted, and she is guarded about touch to her right knee. The current medications included Vicodin, topical Lidoderm cream and topical Solaraze cream. There is previous physical therapy sessions noted in the records. The physician requested treatment included right Knee injection ultrasound guided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee injection, ultrasound guided: 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, Corticosteroid injections.

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

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 traumatic 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. Based on the provided clinical documentation for review and the above ACOEM guidelines, the request is not medically necessary.