

<b>Case Number:</b>	CM15-0116476		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	07/10/2014
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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 65 year old female, who sustained an industrial injury on 07/10/2014. She has reported injury to the neck, bilateral upper extremities, left knee, and low back. The diagnoses have included sprains and strains of neck; muscle spasm, bilateral upper extremities; tinnitus, left ear; contusion, left knee; sprain/strain lumbar region; major depressive disorder; and generalized anxiety disorder. Treatment to date has included medications, diagnostics, physical therapy, cognitive behavioral therapy, and aquatic therapy. Medications have included Advil, Aleve, Gabapentin, Ketamine 5% Cream; and Voltaren Gel 1%. A progress note from the treating physician, dated 05/14/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of pain in the neck, bilateral upper extremity, low back, and left knee; she was recently evaluated for the tinnitus she has been experiencing since her injury; she can barely lift her arms today from raking leaves the day before; she has a throbbing sensation in both arms, as well as muscle soreness in her back; her pain today is rated as a 6/10 on the visual analog scale, and it is normally a 3/10; she feels like her arms are getting weaker; she feels more anxious today; the thought of going back to work makes her very nervous and anxious, and she is not sure if she will be able to handle going back; she found aquatic therapy to be very beneficial; she would be very interested in pursuing a home exercise program in a pool, but does not have access to a pool at her home; and she has headaches and dizziness. Objective findings included an MRI report of the left knee, dated 04/20/2015, which revealed tricompartmental degenerative joint disease, moderate effusion with multi-cystic ganglion just superomedial to the medial femoral condyle, moderate Baker's cyst, and inflammatory changes surrounding the medial collateral ligament. The treatment plan has included the request for one left knee cortisone injection.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**One left knee cortisone injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339; Table 13-6.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. 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 intra-articular 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). 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 (3). In this case, although the injured worker does complain of pain, but at least five of the above criteria have not been. The request for one left knee cortisone injection is not medically necessary.