

<b>Case Number:</b>	CM15-0078382		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	07/03/2007
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	04/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/23/2015

### 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 73 year old female who sustained an industrial injury on 07/03/2007. The injured worker was diagnosed with right chondromalacia; right knee degenerative joint disease with popliteal bursitis, right hip degenerative joint disease, and left sciatica. Treatment to date includes conservative measures, medications, exercise and stretching and Hyalgan injection to the right knee last received on September 9, 2014. According to the primary treating physician's progress report on March 30 2015, the injured worker continues to experience low back, right hip and bilateral knee pain. Examination of the right knee demonstrated full active range of motion with palpable crepitation and heat over the right lateral joint lines and moderate fullness over the popliteal bursa. A positive bow string sign was noted. Current medications are listed as Tylenol #2 and topical analgesics. Treatment plan consists of ice packs, stretching, medication regimen and the current request for a right popliteal bursa injection under ultrasound guidance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Popliteal Bursa Injection under Ultrasound Guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back 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 atraumatic 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. The provided clinical documentation for review does not meet criteria for knee injections as outlined above per the ACOEM and therefore is not medically necessary.