

Case Number:	CM13-0020134		
Date Assigned:	12/11/2013	Date of Injury:	08/20/2008
Decision Date:	01/15/2014	UR Denial Date:	08/20/2013
Priority:	Standard	Application Received:	09/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a male patient with a date of injury of August 20, 2008. A progress report dated November 4, 2013 identifies the subjective complaints stating, "patient is scheduled for preoperative medical clearance with the internist in the very near future. Patient is scheduled for pre-op follow-up with [REDACTED] on November 18, 2013. Patient states that his left knee pain has intensified since his last office visit. The patient denies any fall or strenuous activities that may have contributed to his increased pain. Patient also continues with right knee pain with less intensity compared to the left." Examination identifies, "left knee reveals positive effusion. Patient has flexion contracture present. Patient is able to flex the left knee to 100°. Examination reveals negative Holman sign bilaterally. Negative Pratts sign bilaterally." Diagnoses include status post left shoulder arthroscopic rotator cuff repair with retear and possible mild deltoid injury, right shoulder rotator cuff tear partial versus full thickness, bilateral knee degenerative arthrosis, left knee more severe than right. Treatment plan recommends continuing with home exercise program, ice, elevation, and anti-inflammatory medication. The patient also underwent aspiration and steroid injection of the left knee. A progress report dated October 17, 2013 identifies subjective complaints stating, "[REDACTED] has recommended left total knee arthroplasty." Objective examination findings identify, "right knee has medial joint line tenderness. There is peripatellar tenderness as well." Diagnoses include, right and left knee internal derangement. Treatment plan includes requesting authorization for total knee arthroplasty, prescription for naproxen, Condrolite "which is a cartilage sparing medication, which has been scientifically documented to slow the development of arthritis. The combination of chondroitin and glucosamine is markedly used to aid in maintaining healthy joints," tramadol ER for the t

IMR ISSUES, DECISIONS AND RATIONALES

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

Condrolite: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine Page(s): 50.

Decision rationale: Regarding the request for Condrolite, Chronic Pain Medical Treatment Guidelines state that glucosamine and chondroitin sulfate are recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. A search of the Internet identifies that Condrolite contains glucosamine, chondroitin, and MSM. Guidelines do not contain criteria regarding the use of MSM. Additionally, the request for Condrolite does not include a frequency of utilization, or duration of treatment. The open-ended application of any treatment is generally not supported by guidelines. The request for Condrolite is not medically necessary and appropriate.

Ativan: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter

Decision rationale: Regarding the request for Ativan, Chronic Pain Medical Treatment Guidelines state that benzodiazepines are not recommended for long-term use. Most guidelines limit their use to 4 weeks. Within the documentation available for review, it is unclear what diagnosis the Ativan is being prescribed to treat. Additionally, it is unclear whether the Ativan is being prescribed to treat the accepted work injury. Furthermore, there is no documentation identifying any objective functional improvement as a result of the use of the Ativan. Finally, there is no indication that the Ativan is being prescribed for short-term use, as recommended by guidelines. The request for Ativan is not medically necessary and appropriate.

Tramadol ER 150mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-79.

Decision rationale: California Pain Medical Treatment Guidelines state that tramadol ER is a long acting opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the tramadol ER is improving the patient's function or pain, no documentation regarding side effects, and no discussion regarding aberrant use. The request for tramadol ER is not medically necessary and appropriate.

Refalen 750mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-69.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Guidelines go on to point out the risk of NSAIDs in relation to gastrointestinal and cardiovascular complications. Within the documentation available for review, there is no identification that Relafen is improving the patient's pain or function. Additionally, there is no discussion regarding side effects, or medical history to determine whether the patient has any contraindications to the ongoing use of this medication. Furthermore, guidelines do not support the open-ended ongoing use of nonsteroidal anti-inflammatory medications. The current request does not have a frequency of treatment or duration of treatment. The request for Relafen is not medically necessary and appropriate.

orthopedics consultation regarding the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-344.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation ODG, Knee & Leg Chapter, Total Knee Arthroplasty

Decision rationale: Occupational Medicine Practice Guidelines recommend surgical consultation for patients with activity limitation for more than one month, and failure of exercise program to increase range of motion and strength of musculature around the knee. ODG states that total knee arthroplasty is recommended provided a patient has failed conservative care and medications, clinical findings of limited range of motion, nighttime joint pain, no relief with conservative care, and documentation of functional limitations. Additionally, they recommend that the patient be over 50 years of age with a BMI less than 35, and osteoarthritis present on standing x-ray. Within the documentation available for review, there is no recent documentation with regards to the patient's right knee including failure of conservative treatment, nighttime

joint pain, or standing x-ray documenting loss of chondral space. The request for an orthopedics consultation is not medically necessary and appropriate.

Cidaflex: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

Decision rationale: Regarding the request for Cidaflex, Chronic Pain Medical Treatment Guidelines state that glucosamine and chondroitin sulfate are recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Within the documentation available for review, it is unclear whether the patient is still taking this medication. Additionally, there is no documentation of analgesic efficacy, or objective functional improvement as a result of the use of this medication. In the absence of such documentation, the currently requested Cidaflex is not medically necessary. The request for Cidaflex is not medically necessary and appropriate.