MAXIMUS Federal Services

Case Number:	CM13-0061033		
Date Assigned:	12/30/2013	Date of Injury:	03/19/2008
Decision Date:	05/09/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	12/04/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation 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 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/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:

The patient is a 53-year-old female who was injured on 03/19/2008. The mechanism of injury is unknown. Prior treatment history has included physical therapy, aqua therapy and HEP. The following medications: 1. Nucynta 50 mg, 2. Neurontin 600 mg, 3. Lodine400 mg, 4. Skelaxin 800 mg, 5. Acetaminophen 325 mg, 6. Propoxyphene-apap 50/325 mg. Diagnostic studies reviewed include MRI of the right knee w/o contrast revealing: 1) Mild medial and lateral compartment arthritis. 2) Moderate patellofemoral joint arthritis especially laterally with joint space narrowing, minimal lateral subluxation, subchondral cysts and osteophytes. 3) Small tear of the posterior horn lateral meniscus. 4) Chronic thickening anterior posterior cruciate ligament without tears. 5) No fractures or bony contusions. 6) Moderate sized joint effusion. 7) Extensive motion artifact. PR-2 dated 11/19/2013 documented the patient to have complaints of right knee pain. The pain level has increased since the last visit. She reports a new injury since last visit (she reports tripping and falling more often at home due to right lower extremity weakness and pain. Her activity level has decreased. The patient is taking her medications as prescribed. She states that medications are working well. No side effects reported. Objective findings on exam revealed the patient has an antalgic gait, slowed gait, stooped gait and has an unsteady gait assisted by a walker. Examination of the right knee reveals inspection of the knee joint reveals no erythema or warmth to palpation. There is slight effusion palpable. Range of motion is restricted with no pain. Tenderness to palpation is noted over the right knee. Right knee is stable to varus stress in extension and at 30 degrees. Negative posterior drawer test and reverse point pivot shift test. There is 1+ effusion in the right knee joint. Patellar grind test is positive. McMurray's test is positive. There is hyperalgesia and allodynia around joint. She is wearing two Ace bandages wrapped around the right knee. There is pain with passive right knee extension with tendency towards recurvatum. The right knee is notably more edematous versus the left.

McMurray's, valgus/varus and Lachman's tests are limited due to patient guarding. Examination of the right ankle reveals the patient is wearing a stabilization boot. On neurological examination motor testing limited by pain. Motor strength of EHL is 5/5 in left, knee extensor's 5/5 on left, knee flexors 4/5 on right and 5/5 on left. Sensory examination, sensation to pinprick is decreased over medial calf, lateral calf on right side. Decreased light touch sensation to right lower extremity. Waddell's sign is negative. Diagnosis: reflex sympathetic dystrophy (RSD) lower limb. Treatment Plan: The following items were denied: right Swedish Knee Cage for genu recurvatum and stability; patient with two falls due to pain, hyperextension. She previously received hinged knee brace but it is the wrong size. She has yet to contact Diablo Prosthetics and Orthotics to get a different size. Prescription given for custom knee brace, Aqua therapy and Visco supplementation injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF A SWEDISH KNEE CAGE FOR THE RIGHT KNEE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 1017.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Knee Brace

Decision rationale: According to the ODG - Knee brace is recommended as indicated below. Recommend valgus knee braces for knee OA. Knee braces that produce a valgus moment about the knee markedly reduce the net knee adduction moment and unload the medial compartment of the knee, but could be impractical for many patients. There are no high quality studies that support or refute the benefits of knee braces for patellar instability, ACL tear, or MCL instability, but in some patients, a knee brace can increase confidence, which may indirectly help with the healing process. In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is going to be stressing the knee under load. There are no data in the published peer-reviewed literature that shows that custom-fabricated functional knee braces offer any benefit over prefabricated, off-the-shelf braces in terms of activities of daily living. Criteria for the use of knee braces: Prefabricated knee braces may be appropriate in patients with one of the following conditions: 1. Knee instability 2. Ligament insufficiency/deficiency 3. Reconstructed ligament 4. Articular defect repair 5. Avascular necrosis 6. Meniscal cartilage repair 7. Painful failed total knee arthroplasty 8. Painful high tibial osteotomy 9. Painful unicompartmental osteoarthritis 10. Tibial plateau fracture. Custom-fabricated knee braces may be appropriate for patients with the following conditions which may preclude the use of a prefabricated model: 1. Abnormal limb contour, such as: a. Valgus [knock-kneed] limb b. Varus [bow-legged] limb c. Tibial Varum d. Disproportionate thigh and calf (e.g., large thigh and small calf) e. Minimal muscle mass on which to suspend a brace. 2. Skin changes, such as: a. Excessive redundant soft skin b. Thin skin with risk of breakdown (e.g., chronic steroid use) 3. Severe osteoarthritis (grade III or IV) 4. Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain) 5. Severe instability as noted on physical examination of knee. The PR-2 dated 11/19/2013 documented the patient to

have complaints of right knee pain. The report documents that the patient previously received a hinged knee brace that was the wrong size. The patient had not yet contacted the orthotic provider to get the correct size. It is reasonable that the patient should obtain the correct sized hinged knee brace. This device would be appropriate to improve stability and offload pain in the knee. The medical records do not include a viable rationale to support the medical necessity for another custom knee brace.

HYALURONIC INJECTION FOR RIGHT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The 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 and Leg (updated 06/07/13), Hyaluronic Acid Injections

Decision rationale: According to the Official Disability Guidelines, Hyaluronic acid injections are recommended as a possible option for severe osteoarthritis for patients who have not responded adequately to recommended conservative treatments (exercise, NSAIDs or acetaminophen); to potentially delay total knee replacement, but in recent quality studies the magnitude of improvement appears modest at best. Criteria for Hyaluronic acid injections: 1) Patients experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative nonpharmacologic (e.g., exercise) and pharmacologic treatments or are intolerant of these therapies (e.g., gastrointestinal problems related to anti-inflammatory medications), after at least 3 months; 2) Documented symptomatic severe osteoarthritis of the knee, which may include the following: Bony enlargement; Bony tenderness; Crepitus (noisy, grating sound) on active motion; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Over 50 years of age. 3) Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; 4) Failure to adequately respond to aspiration and injection of intra-articular steroids; 5) Generally performed without fluoroscopic or ultrasound guidance; 6) Are not currently candidates for total knee replacement or who have failed previous knee surgery for their arthritis, unless younger patients wanting to delay total knee replacement. 7) Hyaluronic acid injections are not recommended for any other indications such as chondromalacia patellae, facet joint arthropathy, osteochondritis dissecans, or patellofemoral arthritis, patellofemoral syndrome (patellar knee pain), plantar nerve entrapment syndrome, or for use in joints other than the knee (e.g., ankle, carpo-metacarpal joint, elbow, hip, metatarso-phalangeal joint, shoulder, and temporomandibular joint) because the effectiveness of hyaluronic acid injections for these indications has not been established. The medical records do not establish the patient meets the necessary criteria for consideration of viscosupplementation injections. It is not established that the patient has not responded adequately to recommended conservative nonpharmacologic (e.g., exercise) and pharmacologic treatments, of at least 3 months. The patient stated medications were working well without side effects reports and she had been prescribed aquatic therapy. It would be appropriate to evaluate her response to therapy prior to considering more invasive measures. In addition, the medical records do not document failure to adequately respond to aspiration or injection of intra-articular steroids.