

Case Number:	CM13-0065004		
Date Assigned:	01/03/2014	Date of Injury:	08/19/2013
Decision Date:	07/04/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/12/2013

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 Orthopedic Surgery 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:

This is a 27 year old male with who has reported right knee pain after an injury on 8/19/13. Exam notes from 10/22/13 demonstrate right knee sprain. An MRI of the right knee on 9/24/13 demonstrates focal high grade chondral fissuring and delamination involving the posterior aspect of the lateral femoral condyle. Exam notes from 11/1/13 demonstrate abnormal gait pattern with a limp in the right leg. Diagnoses are right knee strain/sprain, MRI findings of osteochondral defect lateral femoral condyle, and rule out internal derangement. There are requests for MRI of the right knee with arthrogram, surgery, and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI right knee with arthrogram: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, MRI.

Decision rationale: According to the CA MTUS/ACOEM, Knee Complaints Chapter 13, page 341-345 regarding knee MRI. Special studies are not needed to evaluate most knee complaints

until after a period of conservative care and observation. The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: Patient is able to walk without a limp. Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: Joint effusion within 24 hours of direct blow or fall; Palpable tenderness over fibular head or patella; Inability to walk (four steps) or bear weight immediately or within a week of the trauma; Inability to flex knee to 90 degrees. Most knee problems improve quickly once any red-flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Even so, remember that while experienced examiners usually can diagnose an ACL tear in the non acute stage based on history and physical examination, these injuries are commonly missed or over diagnosed by inexperienced examiners, making MRIs valuable in such cases. Also note that MRIs are superior to arthrography for both diagnosis and safety reasons. Table 13-5 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. According to the ODG regarding knee MRI, In most cases, diagnosing osteoarthritis with an MRI is both unnecessary and costly. Although weight-bearing X-rays are sufficient to diagnose osteoarthritis of the knee, referring physicians and some orthopaedic surgeons sometimes use magnetic resonance imaging (MRI) either with or instead of weight bearing X-rays for diagnosis. For total knee arthroplasty (TKA) patients, about 95% to 98% of the time they don't need an MRI. Osteoarthritis patients often expect to be diagnosed with MRIs, and this demand influences MRI use. Average worker's compensation reimbursement is also higher for the knee MRI (████) than for the knee X-rays (████). (Goldstein, 2008) Repeat MRIs are recommended if need to assess knee cartilage repair tissue. In determining whether the repair tissue was of good or poor quality, MRI had a sensitivity of 80% and specificity of 82% using arthroscopy as the standard. (Ramappa, 2007) MRI scans are accurate to diagnose meniscus tears, but MRI is a poor predictor of whether or not the tear can be repaired. Surgeons cannot tell whether the tear will be repairable until the surgery is underway, and it affects recovery because repaired meniscus tears have a more involved recovery compared with surgical removal of the tissue. (Bernthal, 2010) In this case series, in more than half of patients who had an MRI at the request of their referring physician, the MRI was not necessary. MRI was considered unnecessary if: X-rays alone could establish the diagnosis, patellofemoral pain with a normal ligamentous and meniscal exam, the knee pain resolved before seeing an orthopedic surgeon, or the MRI findings had no effect on treatment outcome. MRI studies were deemed necessary if they were indicated by history and/or physical examination to assess for meniscal, ligamentous, or osteochondral injury or osteonecrosis, or if the patient had an unexpected finding that affected treatment. (Khanuja, 2011) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended, but may be appropriate for pain after TKA with a negative radiograph for loosening and low probability of infection. (Weissman, 2011) MRI of knees with no radiographic evidence of osteoarthritis is still likely to identify structural lesions associated with osteoarthritis (i.e., osteophytes, cartilage damage, and bone marrow lesions). (Guermazi, 2012) Indications for

imaging, MRI (magnetic resonance imaging): Acute trauma to the knee, including significant trauma (e.g., motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption. Nontraumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed. Nontraumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary and if internal derangement is suspected. Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected. Nontraumatic knee pain, adult; nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Pellegrini Stieda disease, joint compartment widening). Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Ramappa, 2007) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. (Weissman, 2011)Based upon the records reviewed there is insufficient evidence to support a repeat MRI of the right knee based upon the guidelines listed. Therefore the determination is that the MRI is not medically necessary.

Right knee diagnostic scope surgery, shaving the cartilage lateral femoral condyle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341.345.

Decision rationale: CA MTUS/ACOEM Chapter 13 Knee Complaints, pages 344-345, states regarding meniscus tears, "Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear, symptoms other than simply pain (locking, popping, giving way, recurrent effusion); clear signs of a bucket handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion); and consistent findings on MRI. However, patients suspected of having meniscal tears, but without progressive or severe activity limitation, can be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize healing. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery may not be equally beneficial for those patients who are exhibiting signs of degenerative changes."In this case there is insufficient evidence in the records of a surgical lesion to meet guideline criteria for knee arthroscopy. Therefore the decision is that the proposed surgery is not medically necessary.

Internal medicine evaluation for surgical clearance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Physiotherapy (X 12-18): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

TENs Unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-Op Hot/Cold contrast unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-Op knee immobilizer: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-op crutches: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Continue right knee brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

Decision rationale: There is no evidence of ligamentous instability to warrant continued use of a right knee brace. Therefore the knee brace is not medically necessary.

Tramadol (Ultram) 150MG 1 daily: 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 Opioid management; Page 94, Opioids, steps to avoid misuse/addiction; indications, Chronic back pain; Mechanical and compressive etiologies; and , Tramadol (Ultram) Page(s): 77-81, 94, 80, 81, 113.

Decision rationale: With regards to Tramadol, per the CA MTUS Chronic Pain Medical Treatment Guidelines pg 93-94, Tramadol "is a synthetic opioid affecting the central nervous system. Tramadol is not classified as a controlled substance by the DEA. Side Effects: Dizziness, nausea, constipation, headache, somnolence, flushing, pruritus, vomiting, insomnia, dry mouth, and diarrhea. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Do not prescribe to patients that at risk for suicide or addiction. Warning: Tramadol may produce life-threatening serotonin syndrome, in particular when used concomitantly with SSRIs, SNRIs, TCAs, and MAOIs, and triptans or other drugs that may impair serotonin metabolism. Analgesic dose: Tramadol is indicated for moderate to severe pain. The immediate release formulation is recommended at a dose of 50 to 100mg PO every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day). Ultram ER: Patient currently not on immediate release Tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Patients currently on

immediate release Tramadol calculate the 24-hour dose of IR and initiate a total daily dose of ER rounded to the next lowest 100mg increment (Max dose 300mg/day). (Product information, Ortho-McNeil 2003) (Lexi-Comp,2008)Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence of failure of primary non-steroidal agents or moderate to severe pain to warrant Tramadol. Therefore the use of Tramadol is not medically necessary.

Hydrocodone (Norco) 10/325MG 1 Q4-6H: 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 Opioid management; Opioids, steps to avoid misuse/addiction; indications, Chronic back pain; Mechanical and compressive etiologies Page(s): 77-81, 94,80,81.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines page 78 and 79 regarding on-going management of opioids, On-Going Management. Actions Should Include:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).(g) Continuing review of overall situation with regard to nonopioid means of pain control.(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. In this case the guideline criteria have not been met and Norco is not medically necessary.

Naproxen Sodium (Anaprox) 550MG 1 BID: 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 Medications for chronic pain and NSAIDs, specific drug list & adverse effects and Official Disability Guidelines (ODG), Knee Chapter, Medications, Pain Chapter, NSAIDs Page(s): 60, 70,73.

Decision rationale: Per the MTUS guidelines, Naproxen is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. Per ODG, for acute low back pain & acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting to negative evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. There is no evidence in the medical records of osteoarthritis or a failure of acetaminophen to support medical necessity of this NSAID. Therefore naproxen is not medically necessary.

Omeprazole (Prilosec) 20MG BID: 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 NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Per the CA MTUS regarding Prilosec. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease : (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or Misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. In this case there is lack of medical necessity in the records that the claimant is at risk for gastrointestinal events. Therefore the omeprazole is not medically necessary.