

Case Number:	CM13-0067817		
Date Assigned:	01/03/2014	Date of Injury:	10/13/2003
Decision Date:	06/04/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/18/2013

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 Texas. 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 injured worker is a 62-year-old male who reported an injury on 10/13/2003. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to the cervical spine, right shoulder, low back and knee. The injured worker's treatment history included physical therapy, multiple medications, corticosteroid injections to the knee and lumbar epidural steroid injections. The injured worker was evaluated by an Agreed Medical Examiner on 11/01/2012. It was documented that the injured worker had a history of steroid injections that did not provide significant benefit. It was also documented that the injured worker had a history of surgical intervention to the left knee following physical therapy that failed to provide lasting benefit. The injured worker was evaluated on 10/08/2013. It was documented that the injured worker had neck and low back pain rated at a 7/10 to 8/10. It was noted that the injured worker had complaints of mechanical knee symptoms. It was documented that the injured worker had had a steroid injection approximately 3 months prior to the appointment. Physical findings included tenderness to palpation of the cervical spine and lumbar spine with restricted range of motion of the cervical and lumbar spines. It was documented that the injured worker had normal range of motion of the knee, documented as 130 degrees in flexion and 0 degrees in extension. The injured worker's diagnoses included cervical disc syndrome, right shoulder rotator cuff tear, low back syndrome, lumbar disc syndrome, left knee osteoarthritis, knee medial meniscus tear and L4-5 bilateral radiculopathy. The injured worker's treatment plan included the continuation of medications. The injured worker's medications were listed as Vicodin 5/500 mg, Relafen 750 mg and omeprazole 20 mg. It was documented that the injured worker was provided with Flexeril 7.5 mg to reduce muscle spasming, and an injection of a corticosteroid injection was provided to the injured worker. A recommendation for a referral was provided, and a total knee replacement was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

INJECTION OF CORTISONE TO LIDOCAINE 4:1: 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), Treatment Index, Knee Chapter, Corticosteroid Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346-347.

Decision rationale: The American College of Occupational and Environmental Medicine does recommend 1 to 2 corticosteroid injections as an appropriate treatment for injured workers with knee pain. However, the clinical documentation submitted for review does indicate that the injured worker has had several corticosteroid injections. There was no documentation of functional benefit or pain relief as a result of those injections. Therefore, an additional injection would not be supported. Additionally, the request as it is submitted does not clearly identify a body part. As the injured worker has multiple major joints involved in pain-related complaints, the identification of the body part would be necessary to assess the appropriateness of the request. As such, the requested injection of cortisone to lidocaine 4:1 is not medically necessary or appropriate.

LEFT KNEE REPLACEMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Treatment Index, Knee Chapter, Knee Replacement.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg Chapter, Knee Joint Replacement.

Decision rationale: The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines recommend knee replacement surgery for severe osteoarthritis. Documentation of significant impaired functional benefit supported by the documentation of an imaging study would be needed to support the requested surgery. The clinical documentation submitted for review does not provide any evidence that the injured worker has any functional deficits related to the injured worker's left knee. The clinical documentation clearly identifies that there are no range of motion deficits to support the requested surgery. Additionally, an imaging study documenting severe osteoarthritis was not provided for review. As such, the requested left knee replacement is not medically necessary or appropriate.

RELAFEN 750 MG #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS) Page(s): 67.

Decision rationale: The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended period of time. The California Medical Treatment Utilization Schedule does recommend the use of nonsteroidal anti-inflammatory drugs in the management of chronic pain. However, medications used in the management of chronic pain must be supported by a quantitative pain assessment to support pain relief and evidence of functional benefit. The clinical documentation submitted for review does not provide any evidence of functional benefit or pain relief as a result of the use of this medication. Therefore, the continued use would not be supported. As such, the requested Relafen 750 mg #180 is not medically necessary or appropriate

PRILOSEC 20 MG # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68.

Decision rationale: The California Medical Treatment Utilization Schedule recommends that the use of gastrointestinal protectants be supported by documentation that the injured worker is at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide any evidence of side effects related to medication usage that would require pharmacological intervention. Additionally, there is no recent assessment of the injured worker's gastrointestinal system to support that they are at risk for developing gastrointestinal events related to medication usage. As such, the requested Prilosec 20 mg #120 is not medically necessary or appropriate.

RE-EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Office Visits.

Decision rationale: The California Medical Treatment Utilization Schedule does not specifically identify the criteria for evaluation and management of a diagnosis. The Official Disability Guidelines recommend office visits when injured workers are being treated for chronic pain. However, the request as it is submitted is vague in nature and does not clearly identify the

need for re-evaluation or referral. Therefore, the appropriateness of the request cannot be determined. As such, the requested re-evaluation is not medically necessary or appropriate.