

Case Number:	CM14-0132810		
Date Assigned:	08/22/2014	Date of Injury:	03/26/2010
Decision Date:	09/24/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/19/2014

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 Occupational Medicine 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:

According to the records made available for review, this is a 51-year-old female with a 3/26/10 date of injury. At the time (7/1/14) of request for authorization for Hydrocodone/APAP 10/325mg QTY: 30.00, Lidoderm 5% patch, QTY: 30.00, Left knee cortisone injection, QTY: 1.00, and Left knee brace, QTY: 1.00, there is documentation of subjective (left lower back pain with radiation to posterior thigh, knee anterior/posterior pain, calf weakness, right foot pain with tingling and numbness, right toe weakness, pain rated 8/10, and pain impairs ability to perform activities of daily living) and objective (lumbar range of motion very limited in flexion, extension, lateral rotation, and lateral bending with increased in concordant pain in all planes, 5/5 motor strength in bilateral lower extremities except left knee flexors/extensors, sensation intact in bilateral lower extremities, left knee flexion at 90 degrees and right knee flexion at 120 degrees, tenderness right ankle and left knee joint line, positive impingement test, and straight leg raise positive on left) findings, current diagnoses (lumbar disc with radiculitis, lower back pain, foot pain, joint pain, ankle, and knee pain), and treatment to date (physical therapy, home exercise program, left knee cortisone injection (with significant benefits for a few days), and medications (including ongoing treatment with lidoderm and hydrocodone/APAP)). Regarding Hydrocodone/APAP 10/325mg QTY: 30.00, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone/APAP use to date. Regarding Lidoderm 5% patch, QTY: 30.00, there is no documentation that a trial of first-line therapy has failed and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a

reduction in the use of medications as a result of Lidoderm patch use to date. Regarding Left knee cortisone injection, QTY: 1.00, there is no documentation of symptomatic severe osteoarthritis of the knee and at least 4 of the following: (Bony enlargement; Bony tenderness; Crepitus on active motion; Erythrocyte sedimentation rate less than 40 mm/hr; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Rheumatoid factor less than 1:40 titer; and/or Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm³)), and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of cortisone injection provided to date. Regarding Left knee brace, QTY: 1.00, there is no documentation of patellar instability, anterior cruciate ligament tear, or medical collateral ligament instability; the patient is going to be stressing the knee under load, the brace has been properly fitted and combined with a rehabilitation program, abnormal limb contour, Skin changes, Severe osteoarthritis, and Maximal off-loading of painful or repaired knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-80.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar disc with radiculitis, lower back pain, foot pain, joint pain, ankle, and knee pain. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Hydrocodone/APAP, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone/APAP use to date. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone/APAP 10/325mg QTY: 30.00 is not medically necessary.

Lidoderm 5% patch, QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM (LIDOCAINE PATCH) Page(s): 56-57.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a lidocaine patch. Within the medical information available for review, there is documentation of diagnoses of lumbar disc with radiculitis, lower back pain, foot pain, joint pain, ankle, and knee pain. In addition, there is documentation of neuropathic pain. However, there is no documentation that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed. In addition, given documentation of ongoing treatment with Lidoderm patch, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lidoderm patch use to date. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm 5% patch, QTY: 30.00 is not medically necessary.

Left knee cortisone injection, QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee chapter and knee corticosteroid injections, updated 6/5/14.

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

Decision rationale: MTUS does not address this issue. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of symptomatic severe osteoarthritis of the knee, which requires knee pain which interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease, and at least 5 of the following: (Bony enlargement; Bony tenderness; Crepitus (noisy, grating sound) on active motion; Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Over 50 years of age; Rheumatoid factor less than 1:40 titer (agglutination method); and/or Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm³); failure of conservative

treatment (exercise, NSAIDs or acetaminophen); Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; and The number of injections should be limited to three, as criteria necessary to support the medical necessity of corticosteroid injections to the knee. Within the medical information available for review, there is documentation of diagnoses of lumbar disc with radiculitis, lower back pain, foot pain, joint pain, ankle, and knee pain. In addition, there is documentation of a previous left knee cortisone injection. Furthermore, there is documentation of pain that with functional activities, failure of conservative treatment (physical therapy, home exercise program, lidoderm and hydrocodone/APAP), and one of the following (Over 50 years of age). However, there is no documentation of symptomatic severe osteoarthritis of the knee and at least 4 of the following: (Bony enlargement; Bony tenderness; Crepitus (noisy, grating sound) on active motion; Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Rheumatoid factor less than 1:40 titer (agglutination method); and/or Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm³)); In addition, despite documentation of significant benefits for a few days with previous cortisone injection, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of cortisone injection provided to date. Therefore, based on guidelines and a review of the evidence, the request for Left knee cortisone injection, QTY: 1.00 is not medically necessary.

Left knee brace, QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG0 KNEE, KNEE BRACES).

Decision rationale: MTUS reference to ACOEM Guidelines identifies that a brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability; and that a brace is necessary only if the patient is going to be stressing the knee under load. In addition, MTUS identifies that braces need to be properly fitted and combined with a rehabilitation program. ODG identifies documentation of abnormal limb contour (such as: Valgus [knock-kneed] limb, Varus [bow-legged] limb, Tibial varum, Disproportionate thigh and calf (e.g., large thigh and small calf), or Minimal muscle mass on which to suspend a brace); Skin changes (such as: Excessive redundant soft skin, Thin skin with risk of breakdown (e.g., chronic steroid use), Severe osteoarthritis (grade III or IV), Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain), or Severe instability as noted on physical examination of knee), as criteria necessary to support the medical necessity of custom-fabricated knee braces. Within the medical information available for review, there is documentation of diagnoses of lumbar disc with radiculitis, lower back pain, foot pain, joint pain, ankle, and knee pain. In addition, there is documentation of left knee pain. However, there is no documentation of patellar instability, anterior cruciate ligament

(ACL) tear, or medial collateral ligament (MCL) instability; the patient is going to be stressing the knee under load. In addition, there is no documentation that the brace has been properly fitted and combined with a rehabilitation program. Furthermore, there is no documentation of abnormal limb contour (such as: Valgus [knock-kneed] limb, Varus [bow-legged] limb, Tibial varum, Disproportionate thigh and calf (e.g., large thigh and small calf), or Minimal muscle mass on which to suspend a brace); Skin changes (such as: Excessive redundant soft skin, Thin skin with risk of breakdown (e.g., chronic steroid use), Severe osteoarthritis (grade III or IV), Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain), or Severe instability as noted on physical examination of knee). Therefore, based on guidelines and a review of the evidence, the request for Left knee brace, QTY: 1.00 is not medically necessary.