

Case Number:	CM14-0136554		
Date Assigned:	09/03/2014	Date of Injury:	06/27/2011
Decision Date:	10/14/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/22/2014

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 Physical Medicine and 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 underlying date of injury in this case is 06/27/2011. The date of the initial utilization review under appeal is 08/21/2014. On 08/20/2014, the treating physician saw the patient in followup. The treating physician saw the patient regarding left knee internal derangement, left knee surgery, left knee pain, and left knee degenerative joint disease. The treating physician noted that a requested geniculate nerve block was denied. The treating physician reviewed the patient's history of left knee degenerative joint disease refractory to extensive treatment including physical therapy, NSAIDS, Orthovisc injection, and surgery noted ongoing pain and noted the patient wished to proceed with such an injection. The treating physician provided several literature references to support this request. An initial physician review recommended non-certification of the requested geniculate block with the rationale that the treatment guidelines do not discuss this procedure. The initial review concluded that Pennsaid was appropriate although recommended modification to 1 bottle to allow for medication monitoring.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoroscopically Guided Left Knee Superclateral, Superomedial, Inferomedial Geniculate Nerve Block: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Percutaneous Radiofrequency Treatment for Refractory Anteromedial Pain of Osteoarthritic Knees. Ikeuchi M., Ushida T, Izumi M, Tani T. Pain Medicine. 2011; 12: 546-551 A Cross-Sectional Survey on Prevalence and Risk Factors for Persistent Postsurgical Pain 1 year After Total Hip and Knee Replacement Liu SS, Buvanendran A, Rathmell JP, Sawhney M, Bae JJ, Moric M, Perros S, Pope AJ, Poultsides L, De

Decision rationale: Peer-reviewed literature including that supplied by the treating physician outlines clearly that a geniculate block is an evolving and accepted treatment for patients with osteoarthritis pain in the knee if refractory to past treatment. The lack of comment on a particular treatment in the California Medical Treatment Guidelines does not mean that treatment is not medically necessary. The medical treatment guidelines are presumptive. If those guidelines are silent, then it appropriate to utilize alternative peer-reviewed literature, particularly that supplied by the treating physician. The articles supplied by the treating physician do very clearly support the efficacy of this treatment, and the medical record is documented in detail. Therefore, this treatment is medically necessary.

Pennsaid 2% #1 Bottle With 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Topical Analgesics Page(s): 111.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on topical analgesics states that the efficacy in clinical trials for topical NSAIDS has been inconsistent, and most studies are small and of short duration and that this treatment tends to be effective for short term. The guidelines do clearly support the use of this medication, but long-term efficacy would need to be demonstrated. For this reason, 2 refills would not be indicated. This request is not medically necessary.