MAXIMUS Federal Services

Case Number:	CM14-0141974		
Date Assigned:	10/16/2014	Date of Injury:	07/15/2002
Decision Date:	11/18/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	09/02/2014

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 Internal 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:

The patient is a 74-year-old female with a date of injury of 07/15/2002. The listed diagnoses per [redacted] are discogenic lumbar condition; internal derangement of knee on the right, status post meniscectomy with MRI showing degenerative changes in 2006; ankle inflammation with MRI in 2005 showing some arthritic changes; weight gain of 15 pounds; and element of sleep depression and stress. According to progress report 07/16/2014, the patient presents with low back, left knee, and left ankle pain. The patient has been deemed permanent and stationary by [redacted]. It was noted that the patient had an arthroscopic right knee surgery in the past. Date of surgery is not noted. Objective findings noted "Tenderness along the medial knee and patellofemoral joint of the left side is noted. So, at least there are 2 compartment diseases. The patient has weakness to resisted function. Knee extension is 180 degrees and flexion is 90 degrees." Examination on 04/21/2014 revealed "Patient has tenderness along the lumbar paraspinal muscles. Lumbar flexion is 40 degrees and extension is 30 degrees. Knee extension is 170 degrees and flexion 110 degrees. She has crepitation with range of motion. There is also pain across the joint line medially and laterally." Utilization review denied the request on 08/05/2014. Treatment reports from 01/29/2014 through 09/15/2014 were reviewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Protonix 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: This patient presents with chronic low back and left knee pain. The provider is requesting a refill of Protonix 20 mg #60. The MTUS Guidelines page 68 and 69 states that Omeprazole is recommended with precaution for patients at risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. This patient's medication regimen includes Norco 10/325 mg, Mirtazapine 15 mg, Tramadol ER 150 mg, Flexeril 7.5 mg, and Protonix 20 mg. In this case, there is no indication that the patient is taking NSAID to consider the use of Protonix. Furthermore, the provider provides no discussion regarding GI issues such as gastritis, ulcers, or reflux that would require the use of this medication. Therefore, this request is not medically necessary.

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One prescription of Terocin patches #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Page(s): 112.

Decision rationale: Progress report 07/16/2014 states, "I am requesting also respective authorization for Terocin patches 30 of them." It is unclear when the patient was first prescribed

Terocin patches. The MTUS Guidelines page 112 states under Lidocaine, "Indications are for neuropathic pain, recommend for localized peripheral pain after there has been evidence of trial of first line therapy." In this case, the patient does not present with neuropathic pain that is peripheral and localized. Therefore, this request is not medically necessary.

MRI of the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341, 342. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) under its knee chapter, MRI

Decision rationale: The provider is requesting an MRI of the left knee. [redacted], in his progress reports, indicates that the patient has had an MRI of the left knee in 2006 which revealed internal derangement and "degenerative changes in other compartment." ACOEM Guidelines chapter 13 pages 341 and 342 states "special studies are not needed to evaluate most complaints until after a period of conservative care and observation. For patients with significant hemarthrosis and a history of acute trauma, radiograph is indicated to evaluate for fracture." Official Disability Guidelines may be more appropriate at addressing chronic knee condition. Official Disability Guidelines under its knee chapter states that an MRI is reasonable if internal derangement is suspected. In this case, the patient has already had an MRI of the left knee that confirmed internal derangement. The MRI was from a number of years ago, but the provider does not explain why another set is needed other than for subjective pain. There is no new injury, a recent set of x-rays to review, no new exam findings to warrant an updated MRI. Therefore, this request is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 53 and 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar and Thoracic (Acute and Chronic) and Neck and Upper Back (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: [redacted], in his reports, indicates that the patient has had an MRI of the lumbar spine in 2006 which "showed disk disease at L4 to L5." He also states that nerve conduction studies were performed in 2012 which showed some mild peroneal changes. He is requesting a repeat MRI of the lumbar spine to "look for the progression of disease." For special diagnostics, ACOEM Guidelines page 303 states "unequivocal objective findings that identify specific nerve compromise on the neurological examination is sufficient evidence to warrant imaging in patients who do not respond well to treatment and who would consider surgery as an option. When the neurologic examination is less clear, however, further physiologic evidence of

nerve dysfunction should be obtained before ordering an imaging study." In this case, the provider would like an updated MRI for patient's continued pain. However, examination findings do not confirm neurologic deficits such as weakness, reflex changes, etc. Furthermore, there are no red flags, significant changes in exam, or new location of symptoms to require additional investigation. Therefore, this request is not medically necessary.

Trigger point injection of the left iliac crest: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

Decision rationale: The provider is requesting trigger point injection of the left iliac crest. He does not provide a rationale for this request. The MTUS Guidelines page 122 under its chronic pain section has the following regarding trigger point injections, "Recommended only for myofascial pain syndrome with limited lasting value, not recommended for radicular pain." MTUS further states that all criteria need to be met including documentation of trigger points (circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain) symptoms persist for more than 3 months, medical management therapy, radiculopathy is not present, no repeat injections unless a greater than 50% relief is obtained for 6 weeks, etc. In this case, the provider does not describe any local twitch response or taut band as required by MTUS. Therefore, this request is not medically necessary.

Synvisc series of three injections of the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339 and 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Lower Leg (Acute and Chronic)

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

Decision rationale: This patient presents with chronic low back and left knee pain. The provider has requested series of 3 Synvisc injections to the left knee. The MTUS Guidelines do not discuss Hyaluronic acid knee injections. Therefore, return to Official Disability Guidelines for further discussion. Official Disability Guidelines recommends under its Knee Chapter, "Hyaluronic acid injection as a possible option for severe osteoarthritis who have not responded adequately to recommend a conservative treatments including exercise, NSAIDs, or Acetaminophen to potentially delay total knee replacements or who have failed the previous knee surgery for arthritis, but in recent quality studies, the magnitude of improvement appears modest. The medical file indicates that treatment history for this patient includes cortisone and synvisc injections. The dates of the injections and the outcome are not provided. There are no x-rays to indicate osteoarthritis. MRI of the left knee from 2006 showed degenerative diseases. In

this case, Official Disability Guidelines do not recommend repeating the injection unless there has been a significant reduction of symptoms lasting more than 6 months. The provider has not documented reduction in symptoms from prior injections; therefore, repeat injections are not indicated. Therefore, this request is not medically necessary.

Cortisone injection to the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg chapter, cortisone injection

Decision rationale: This patient presents with chronic low back and left knee pain. The provider is requesting a cortisone injection to the left knee. The ACOEM Chapter 13 page 339 does not support routine use of cortisone injections for knee. Official Disability Guidelines under its Knee & Leg chapter has the following on cortisone injection, "Recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritis knee pain 1 week after injection. The beneficial effect can last 3 to 4 weeks, but it is unlikely to continue beyond that. Evidence supports short term (up to 2 weeks) improvement in symptoms of osteoarthritis of the knee after intra-articular corticosteroid injection." In this case, the provider does not discuss when the last cortisone injection was. The patient did try the injection in the past without documented relief. Therefore, this request is not medically necessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 116.

Decision rationale: The provider is requesting a TENS unit. Utilization review denied the request stating, "The provider does not discuss duration of TENS unit." Per MTUS Guidelines 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality but a one-month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom-limb pain, and multiple scoliosis. When a TENS unit is indicated a 30-day home trial is recommended and with documentation of functional improvement, additional usage may be indicated. In this case, the provider is requesting a TENS unit, but does not document a successful home one-month trial. Therefore, this request is not medically necessary.

Unknown chiropractic treatments: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: This is a request for unknown chiropractic treatments. For manual therapy, the MTUS recommends and optional trial of 6 visits over 2 weeks with evidence of functional improvement, total of up to 18 visits over 6 to 8 weeks. The provider in his progress report 03/18/2013, indicates that the patient was partially approved for the originally requested 7 sessions. Utilization review indicates that the patient was approved for 3 visits. It is unclear as to how many treatments the patient has had thus far and how many additional treatments the provider is requesting. In this case, the provider is requesting additional treatment without documentation or discussion of functional improvement. Labor Code 9792.20(e) defines functional improvement as significant improvement in ALDs, a reduction in work restrictions, and decreased dependence on medical treatment. Given the lack of documented functional improvement from prior chiropractic treatments, recommendation for additional treatment is not supported. Therefore, this request is not medically necessary.