

Case Number:	CM14-0181483		
Date Assigned:	11/06/2014	Date of Injury:	08/06/2009
Decision Date:	12/11/2014	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	10/31/2014

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 Family 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:

This 59-year old landscape and irrigation technician reported injuries to his back and both knees due to attempting to move a large boulder at work on 12/18/12. He subsequently reported a right shoulder injury due to a fall when his knees gave out in May of 2013. Treatment has included medications, physical therapy, arthroscopic surgery to both knees, a steroid injection to his right knee, and facet joint injections in his back. His medical history is remarkable for diabetes, and for atrial fibrillation for which he is on anticoagulation. There are several QME reports in the file, the last of which (8/23/12) documents that the patient had had an episode of atrial fibrillation for which he had been hospitalized, and that he is now taking anticoagulants. The primary treating physician referred the patient to an orthopedist, in whose office he has been seen several times. The documented chief complaint for all orthopedic visits was right knee pain. Physical therapy was prescribed, and a cortisone injection to the right knee was performed without significant improvement in pain or function. An MRI of the R knee was performed on 5/18/14, which revealed some thinning of the articular cartilage of the medial femoral condyle and medial tibial plateau, with medial compartment joint space narrowing. The findings were interpreted by both the radiologist and the orthopedist as compatible with mild right knee arthritis. On 7/31/14, the orthopedist reports that the patient's knee pain is unchanged. Documented findings include right antalgia. Both the presence and absence of a right knee effusion are documented, as well as normal and decreased range of motion of the right knee. The medial joint line of the right knee is tender, and McMurray's test is positive. There is mild crepitus with knee motion. Significantly, the orthopedist specifically documents that the patient has no history of palpitations, and is taking only Glucophage and atenolol. The plan includes a request for a Supartz injection to the right knee. The patient was seen in his primary treater's office on 7/14/14 and 10/1/14. The 7/14/14 note documents back and bilateral knee pain. The

10/1/14 note documents low back, right hip and knee pain. Documented medications at both visits include Duragesic patch, Norco 10/325, Zanaflex, Ambien, Lexapro and blood thinners. Exam is documented as "unchanged" at both visits. Diagnoses include low back pain with disk protrusions and facet arthritis; status post (s/p) right knee arthroscopy (with MRI findings from 7/16/12 which revealed degenerative changes); s/p left knee arthroscopy with 7/16/12 MRI findings that do not show arthritis; bilateral hip and right shoulder pain; and electromyography (EMG) suggestive of lower extremity sensory polyneuropathy. Treatment plan includes a request to authorize bilateral knee injections of Supartz "as recommended by the orthopedist" though the orthopedist in fact only requested a right knee injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Supartz injection to the bilateral knees: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg chapter, criteria for Hyaluronic acid Injections and Other Medical Treatment Guideline or Medical Evidence: UptoDate, an on-line evidence-based review service for clinician (www.uptodate.com), Hyaluronate derivatives: Drug information

Decision rationale: Supartz is brand-name hyaluronic acid, which is also called hyaluronate. The ODG reference cited above states that hyaluronic acid injections are recommended as a possible option for severe osteoarthritis for patients who have not responded adequately to recommended conservative treatments, to potentially delay total knee replacement, but in recent quality studies the magnitude of improvement appears modest at best. A recent meta-analysis on 89 randomized trials, which included over 12,500 patients, concluded that hyaluronic acid injections produced minimal or nonexistent effects on pain and function in patients with knee osteoarthritis, but did increase the risks for serious adverse events and local adverse reactions. The criteria for hyaluronic acid knee injections include that the patient must be experiencing significant symptomatic osteoarthritis, which has not responded adequately to conservative non-pharmacologic measures (e.g. exercise), and pharmacologic treatments, or are intolerant of these therapies (e.g. gastrointestinal problems related to anti-inflammatory medications), after 3 months. The patient must have documented severe osteoarthritis of the knee, which may include bony enlargement, bony tenderness, crepitus on active motion; with less than 30 minutes of morning stiffness and no palpable warmth of synovium; and age over 50. The pain must interfere with functional activities such as walking and prolonged standing, and must not be attributable to other joint disease. There must be failure to adequately respond to aspiration and injection of intra-articular steroids. The patient should not be a current candidate for total knee replacement or have failed previous knee surgery for arthritis. (A previous statement in the same reference makes it clear that these surgeries include arthroscopic debridement.)The UptoDate reference lists systemic bleeding disorders as a contraindication to Monovisc, which is

chemically similar to, but not identical to Supartz. The clinical record in this case does not support the performance of Supartz injections to both knees. This patient clearly has bilateral knee pain, which is worse on the right. Exam findings on the right include right antalgia, jointline tenderness and bony crepitus. However, his MRI findings show only mild arthritis on the right. This raises the question of whether the patient's right knee pain could be accounted for by another diagnosis, such as right hip arthritis, or lumbar radiculopathy. There is no documentation regarding morning stiffness or lack thereof, which would be indicative of rheumatoid arthritis. It is not clear that the patient has tried and failed a course of anti-inflammatory medication, which is the appropriate first-line treatment for osteoarthritis (although now that he is on anti-coagulants, such a trial would be contraindicated.) The documentation is even less complete regarding the left knee. The only left knee MRI report on record does not reveal any evidence of osteoarthritis, and there is no documented exam by either the primary treater or by the consulting orthopedist which includes abnormal physical findings of the left knee. Finally, the orthopedist's complete unawareness of the patient's history of atrial fibrillation and of the fact that he is taking anti-coagulants means that he may be recommending a procedure which is contraindicated. Based on the evidence-based citations above and on the clinical documentation provided for my review, bilateral knee injections with Supartz are not medically necessary. They are not medically necessary, because neither the primary treater nor the orthopedist has documented that the patient has significant symptomatic osteoarthritis in the left knee, and because it is not clear that osteoarthritis is primarily responsible for the patient's right knee pain. Since the patient has already had bilateral arthroscopic debridement of his knees, he may not be a good candidate for Hyaluronate injection. Finally it is not clear that the requesting orthopedist is aware that the patient is taking anticoagulants, which may increase the risks of intra-articular Supartz injection. Given that there is increasing evidence that hyaluronic injections are at best minimally effective, it is medically unnecessary to perform this procedure and to put this patient at risk for the major side effects that can occur if he continues (or discontinues) anticoagulation.