MAXIMUS Federal Services

Case Number:	CM14-0030140		
Date Assigned:	06/20/2014	Date of Injury:	12/06/2012
Decision Date:	07/17/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/10/2014

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, has a subspecialty in Interventional Spine, 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 38-year-old female with date of injury of 12/06/2012. The listed diagnosis per the provider dated 02/11/2014 are: status post right knee scope, medial meniscus repair, 06/12/2013, suprapatellar spur, left ankle sprain/strain, sprain of the unspecified site of the knee and the leg, and 0steoarthritis (per [redacted]). According to this handwritten report, the patient complains of right knee locking with radiating pain into the lateral thigh with reports that medications do not help control the pain. The patient states that her pain is worsening and describes it as sharp burning that is constant and severe in nature. The objective findings shows the right knee shows moderate swelling on peripatellar. There is tenderness upon palpation of the medial joint line greater than the lateral joint line. The knees are also positive for crepitus and grind. The patient also has a slow and guarded gait. The utilization review denied the request on 02/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

SYNVISC INJECTION SERIES OF THREE (3) FOR THE RIGHT KNEE (6ML, 48MG): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Hyaluronic acid injections.

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

Decision rationale: This patient presents with chronic right knee pain. The patient is status post right knee arthroscopy and medial meniscus repair. The treating physician is requesting a Synvisc injection series of 3 for the right knee. The MTUS and ACOEM Guidelines do not address this request. However, Official Disability Guidelines (ODG) on Synvisc-One states that it is recommended as a possible option for severe osteoarthritis for patients who have not responded adequately to recommending conservative treatments including exercise, non-steroidal anti-inflammatory drugs (NSAIDs), or acetaminophen to potentially delay total knee replacement, but in recent quality studies, the magnitude of improvement appears to be modest at best. The reviews of the medical records show that the patient has not had a previous Synvisc injection for the right knee. The progress report dated 08/30/2013 referenced a 07/25/2013 report documenting that the patient has a diagnosis of osteoarthritis of the knee by [redacted]. In the same report, the patient has utilized ibuprofen and Norco. In this case, the patient does have a diagnosis of osteoarthritis of the knee and has utilized conservative treatments in the past with minimal relief. The request for a series of three Orthovisc injections for the right knee is reasonable. The recommendation is for authorization.

ULTRAM ER (TRAMADOL 150MG) ONE (1) TO TWO (2) BY MOUTH (PO) EVERY DAY (QD), AS NEEDED (PRN) FOR PAIN #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: This patient presents with chronic right knee pain. The treating physician is requesting Ultram. For chronic opiate use, the MTUS Guidelines require specific documentations regarding pain and function. The MTUS requires "pain assessment" that requires current pain; least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioids; how long it takes for pain relief; and how long pain relief lasts. Furthermore, "the 4As for ongoing monitoring" are required which includes: analgesia, activities of daily living (ADLs), adverse side effects, and aberrant drug seeking behavior. The review of records showed that the patient has been taking Ultram since 09/23/2013. The report dated 02/11/2014 documents, "Reports prescription medications do not help control pain." In this case, the treating physician has documented that pain medications have not been effective in controlling the patient's pain levels. Therefore, the continued use of Ultram is not recommended. The recommendation is for denial and slow tapering of the opiate.

LIDODERM PATCH, #30, APPLY ONE (1) PATCH EVERY DAY (QD) TO THE RIGHT KNEE: Upheld

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

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

Decision rationale: This patient presents with chronic right knee pain. The treating physician is requesting Lidoderm patches. The MTUS Guidelines on Lidoderm patches states, "Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line treatment (tricyclic, norepinephrine reuptake inhibitor (SNRI), antidepressants, or an anti-epileptic drug (AED) such as gabapentin or Lyrica). This is not the first-line treatment and is only Food and Drug Administration (FDA)-approved for post-herpetic neuralgia." This localized peripheral pain refers to neuropathic pain. The patient's current list of medications includes Voltaren gel, Tramadol, and Fexmid. The review of records showed that the patient has not used Lidoderm in the past. However, this patient does not present with localized peripheral pain that is neuropathic. Furthermore, documents show that the patient has not trialed SNRI, antidepressants, or AED required by the MTUS Guidelines. Thus, the recommendation is for denial.

VOLTAREN XR (DICLOFENANC ER 100MG), ONE (1) BY MOUTH (PO) EVERY DAY (QD) #30 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: This patient presents with chronic right knee pain. The treating physician is requesting refill for Voltaren gel. The MTUS Guidelines on topical analgesic states that it is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, Voltaren gel 1% (Diclofenac) is indicated for relief of osteoarthritis, pain in joints that lend themselves to topical treatment such as ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The records show that the patient has been utilizing Voltaren Gel since 12/02/2013. However, none of the reports provided any documentation of efficacy as it relates to the use of this medication. In this case, while the patient has a diagnosis of osteoarthritis of the knee, continued use of this medication is not warranted given the lack functional improvement relating to the use of Voltaren Gel. The recommendation is for denial.

FEXMID (CYCLOBENZAPRINE 7.5MG) ONE (1) BY MOUTH (PO) TWICE A DAY (BID) #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available).

Decision rationale: This patient presents with chronic right knee pain. The treating physician is requesting a refill for Fexmid. The MTUS Guidelines, on muscle relaxants for pain, recommend non-sedating muscle relaxants with caution as second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Furthermore, under cyclobenzaprine, the MTUS states that it is recommended for a short course of therapy with limited mixed evidence. It does not allow for chronic use. The reviews of the medical records show that the patient has been prescribed cyclobenzaprine since 09/23/2013. In this case, the MTUS does not recommend the long-term use of this medication. As such, the recommendation is for denial.