

Case Number:	CM14-0053194		
Date Assigned:	08/13/2014	Date of Injury:	06/29/2006
Decision Date:	09/16/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	04/21/2014

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 Orthopedic Surgery 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 is a 46-year-old female who sustained a vocational injury working as a CNA on 06/29/06. The report of an MR arthrogram of the right knee dated 12/05/12 showed no fractures or dislocations, Grade III tears of the anterior and posterior horns of the medial meniscus, sprain of the anterior cruciate medial collateral ligaments, a cyst in the midline posterior to the knee joint which filled with gadolinium, chondromalacia of the patella, medial and lateral compartment syndrome of the knee, arthritic changes and superior plica. The office note dated 06/24/14 noted complaints of constant pain in the right knee and difficulty walking and standing. It was documented that she was taking Lunesta. On examination, she had tenderness to palpation over the right knee, range of motion was within normal limits with pain at the endpoints, she was able to half squat with support but with pain, and she had considerable crepitus palpated. Diagnosis was sprain of the anterior cruciate ligament and medial collateral ligament, chronic partial tears of the anterior cruciate ligament of the right knee, a tear of the anterior and posterior horn of the medial meniscus of the right knee, tibiofemoral osteoarthritis medial rather than lateral of the right knee and mucoid degeneration of the lateral meniscus of the right knee. In addition to being status post arthroscopy on 06/21/07, conservative treatment included Vicodin, Flexeril, Lunesta and Xanax.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Knee Arthroscopy,: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345; Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee & Leg chapter: Arthroscopic surgery for osteoarthritis Not recommended. Arthroscopic lavage and debridement in patients with osteoarthritis of the knee is no better than placebo surgery, and arthroscopic surgery provides no additional benefit compared to optimized physical and medical therapy. (Kirkley, 2008) (Marcus, 2002) (Moseley, 2002) In the Meniscal Tear in Osteoarthritis Research (METEOR) trial, there were similar outcomes from PT versus surgery (Katz, 2013) In this RCT, arthroscopic surgery was not superior to supervised exercise alone after non-traumatic degenerative medial meniscal tear in older patients. (Herrlin, 2007).

Decision rationale: The current request is for a right knee arthroscopy. California ACOEM Guidelines note that there should be failure of an exercise program to increase range of motion and strength of the musculature around the knee. Official Disability Guidelines note that surgical intervention in the form of arthroscopy in individuals who have underlying moderate to severe degenerative change is not recommended. Documentation presented for review suggests the claimant has significant underlying osteoarthritis and has not attempted, failed or exhausted conservative treatment which should include antiinflammatories, home exercise program, formal physical therapy and consideration of intraarticular corticosteroid injections for diagnostic and therapeutic intervention. In the setting of moderate to severe arthritis and considering surgical intervention in the form of arthroscopy, it would be medically reasonable to proceed with injection therapy in the form of intraarticular cortisone injections and also consideration of viscosupplementation prior to considering surgical intervention. Therefore, based on the documentation presented for review and in accordance with California ACOEM and Official Disability Guidelines, the request for the right knee arthroscopy is not medically necessary.

Post Operative Physical Therapy; 3x/Week for 4/Weeks (12 Sessions): Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The proposed right knee arthroscopy and partial medial meniscectomy is not recommended as medically necessary. The subsequent request for possible patelloplasty is also not medically necessary.

X-Force Stimulator Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The proposed surgery is not recommended as medically necessary. Therefore, the request for X-Force Stimulator is also not medically necessary.

Flexeril 10mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Sedating Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Cyclobenzaprine (Flexeril) Page(s): 63-64, 42-43, 41-42.

Decision rationale: In regards to the seventh request for Flexeril 10 mg, dispensed #30, California Chronic Pain Treatment Guidelines note that Flexeril should be used in a short-term use of nonsedating muscle relaxants as a second line option to manage acute pain and exacerbations of chronic pain associated with muscle spasms. Documentation suggests the claimant has been using the muscle relaxants for long-term treatment and there appears to be no documentation of an acute pain or flare up consistent with exacerbation of chronic pain and subsequently the request does not meet with California MTUS Chronic Pain Treatment Guidelines and recommendations and subsequently is not medically necessary.

Lunesta 1mg, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Eszopicolone (Lunesta).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Mental chapter: Eszopicolone (Lunesta) Not recommended for long-term use, but recommended for short-term use. See Insomnia treatment. See also the Pain Chapter. Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In this study, eszopicolone (Lunesta) had a Hazard ratio for death of 30.62 (C.I., 12.90 to 72.72), compared to zolpidem at 4.82 (4.06 to 5.74). In general, receiving hypnotic prescriptions was associated with greater than a threefold increased hazard of death even when prescribed less than 18 pills/year. (Kripke, 2012) The FDA has lowered the recommended starting dose of eszopiclone (Lunesta) from 2 mg to 1 mg for both men and women. Previously recommended doses can cause impairment to driving skills, memory, and coordination as long as 11 hours after the drug is taken. Despite these long-lasting effects, patients were often unaware they were impaired. (FDA, 2014).

Decision rationale: The California MTUS and ACOEM Guidelines do not address this request. The Official Disability Guidelines do not recommend Lunesta for long-term use but only recommended for short-term use for insomnia treatment. Official Disability Guidelines recommend limiting the use of three weeks maximum in the first two months of injury only and to discourage use in the chronic phase. Currently documentation presented for review suggests that the medication has been used on a chronic basis and it would be recommended to discontinue the medication and subsequently medical necessity cannot be confirmed and is therefore not medically necessary.

Lyrica 50mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica, no generic available Page(s): 19-20,99.

Decision rationale: In regards to the request for Lyrica 50 mg, dispensed #60, California Chronic Pain Medical Treatment Guidelines have been referenced and note that Lyrica has been approved and given an indication by the FDA for the diagnoses of diabetic neuropathy and post hepatic neuralgia. Currently, there is no documentation presented for review suggesting the claimant has either diabetic neuropathy or postherpatic neuralgia, and subsequently the ongoing use of Lyrica has not been medically established and is thus not medically necessary.

Xanax 1mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24,123.

Decision rationale: In regards to the request for Xanax 1 mg, dispensed #30, California Chronic Pain Medical Treatment Guidelines note that benzodiazepines of which Xanax is a classification, are not recommended for long-term use because the efficacy is unproven and there are risks of dependence. Chronic Pain Guidelines limit the use of up to four weeks and diagnosis presented for review suggests the claimant has been on the medication for quite some time and previous utilization review determinations have recommended and provided weaning schedules. Therefore the request is not medically necessary.

CPM (Continuous Passive Motion) Rental; 14 Days: Upheld

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 Official Disability Guidelines (ODG); Knee & Leg chapter: CPM Continuous passive motion (CPM) Recommended as indicated below, for in-hospital use, or for home use in patients at risk of a stiff knee, based on demonstrated compliance and measured improvements, but the beneficial effects over regular PT may be small. Routine home use of CPM has minimal benefit. Although research suggests that CPM should be implemented in the first rehabilitation phase after surgery, there is substantial debate about the duration of each session and the total period of CPM application. A Cochrane review on this topic concluded that short-term use of CPM leads to greater short-term range of motion. But in a recent RCT results indicated that routine use of prolonged CPM should be reconsidered, since neither long-term effects nor better functional performance was detected. The experimental group received CPM + PT in the home situation for 17 consecutive days after surgery, whereas the usual care group received the same treatment during the in-hospital phase (i.e. about four days), followed by PT alone (usual care) in the first two weeks after hospital discharge. (Lenssen, 2008) Continuous passive motion (CPM) combined with PT, may offer beneficial results compared to PT alone in the short-term rehabilitation following total knee arthroplasty. Results favoring CPM were found for the main comparison of CPM combined with physical therapy (PT) versus PT alone at end of treatment. For the primary outcomes of interest, CPM combined with PT was found to statistically significantly increase active knee flexion and decrease length of stay. CPM was also found to decrease the need for post-operative manipulation. CPM did not significantly improve passive knee flexion and passive or active knee extension. (Milne-Cochrane, 2003) (Kirschner, 2004) (Brosseau, 2004) (Bennett, 2005) (Lenssen, 2006) Continuous passive motion can stimulate chondrocyte production of proteoglycan 4 (PRG4), a molecule found in synovial fluid with putative lubricating and chondroprotective properties. (Nugent-Derfus, 2006) A recent Cochrane review concluded that there is high-quality evidence that continuous passive motion increases passive knee flexion range of motion (mean difference 2 degrees) and active knee flexion range of motion (mean difference 3 degrees), but that these effects are too small to be clinically worthwhile, and there is low-quality evidence that continuous passive motion has no effect on length of hospital stay but reduces the need for manipulation under anaesthesia. (Harvey, 2010) The adjunctive home use of CPM may be an effective treatment option for patients at risk of knee flexion contractures, regardless of whether the patient is being treated as part of a worker's compensation claim or not. Recent literature suggests that routine home use of CPM has minimal benefit when combined with standard physical therapy, but studies conducted in a controlled

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Q-Tech Recovery System Rental; 15 Days: Upheld

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 Official Disability Guidelines (ODG) Game Ready accelerated recovery system Recommended as an option after surgery, but not for nonsurgical

treatment. See Continuous-flow cryotherapy. The Game Ready system combines Continuous-flow cryotherapy with the use of vaso-compression. While there are studies on Continuous-flow cryotherapy, there are no published high quality studies on the Game Ready device or any other combined system. However, in a recent yet-to-be-published RCT, patients treated with compressive cryotherapy after ACL reconstruction had better pain relief and less dependence on narcotic use than patients treated with cryotherapy alone. (Waterman, 2011) Other Medical Treatment Guideline or Medical Evidence:
<http://www.dir.ca.gov/dwc/IMR/IMR%20Decisions/IMR%20Decisions%2013-001000%20thru%2013-004999/IMR-13-4028.pdf>** website above notes that MAXIMUS Federal Services, Inc. has determined the request for X-Force Stim Unit is not medically necessary and appropriate. ***.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Crutches: Upheld

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 Official Disability Guidelines (ODG); Knee and Leg chapter: Walking aids (canes, crutches, braces, orthoses, & walkers) Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed

ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. Cane use, in conjunction with a slow walking speed, lowers the ground reaction force, and decreases the biomechanical load experienced by the lower limb. The use of a cane and walking slowly could be simple and effective intervention strategies for patients with OA. In a similar manner to which cane use unloads the limb, weight loss also decreases load in the limb to a certain extent and should be considered as a long-term strategy, especially for overweight individuals. (Reeves, 2011).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

ROM (Range of Motion) Brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee and Leg chapter: Knee brace Recommended as indicated below. Recommend valgus knee braces for knee OA. Knee braces that produce a valgus moment about the knee markedly reduce the net knee adduction moment and unload the medial compartment of the knee, but could be impractical for many patients. There are no high quality studies that support or refute the benefits of knee braces for patellar instability, ACL tear, or MCL instability, but in some patients a knee brace can increase confidence, which may indirectly help with the healing process. In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is going to be stressing the knee under load. (Bengal, 1997) (Crossley, 2001) (D'hondt-Cochrane, 2002) (Miller, 1997) (Yeung-Cochrane, 2002) (Van Tiggelen, 2004) There are no data in the published peer-reviewed literature that shows that custom-fabricated functional knee braces offer any benefit over prefabricated, off-the-shelf braces in terms of activities of daily living. (BlueCross BlueShield, 2004) The use of bracing after anterior cruciate ligament (ACL) reconstruction cannot be rationalized by evidence of improved outcome including measurements of pain, range of motion, graft stability, or protection from injury. (Wright, 2007) Among patients with knee OA and mild or moderate valgus or varus instability, a knee brace can reduce pain, improve stability, and reduce the risk of falling. (Zhang, 2008) Patellar taping, and possibly patellar bracing, relieves chronic knee pain, according to a recent meta-analysis. Patellar taping may be preferred over bracing due to the fact that there is much more evidence for taping than bracing, and also because taping produces better clinical results in terms of reductions in pain than patellar bracing, plus patients are more active in their rehabilitation with taping than with bracing. (Warden, 2008) This study recommends the unloader (valgus) knee brace for pain reduction in patients with osteoarthritis of the medial compartment of the knee. (Gravlee, 2007) Evidence that knee braces used for the treatment of osteoarthritis mediate pain relief and improve function by unloading the joint (increasing the joint separation) remains inconclusive. When knees with medial compartment osteoarthritis are braced, neutral alignment performs as well as or better than valgus alignment in reducing pain, disability, muscle cocontraction, and knee adduction excursions. Pain relief may result from diminished muscle cocontractions rather than from so-called medial compartment unloading. (Ramsey, 2007) (Chew, 2007) The results of this

systematic review suggest that knee braces and foot orthoses are effective in decreasing pain, joint stiffness, and drug dosage, and they also improve proprioception, balance, Kellgren/Lawrence grading, and physical function scores in subjects with varus and valgus

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Re-Evaluation with Internal Medicine Specialist:

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): Independent Medical Examinations and Consultations Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: California ACOEM Guidelines support referral for consultation with a specialist when there is an identified medical problem or when second opinion for treatment is desired. In this case there is no documentation to determine why the referral for internal medicine consultation is being requested. Therefore, the request cannot be recommended and as such is not medically necessary.

Partial Medial Meniscectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345; Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Knee and Leg chapter: Arthroscopic surgery for osteoarthritis Not recommended. Arthroscopic lavage and debridement in patients with osteoarthritis of the knee is no better than placebo surgery, and arthroscopic surgery provides no additional benefit compared to optimized physical and medical therapy. (Kirkley, 2008) (Marcus, 2002) (Moseley, 2002) In the Meniscal Tear in Osteoarthritis Research (METEOR) trial, there were similar outcomes from PT versus surgery (Katz, 2013) In this RCT, arthroscopic surgery was not superior to supervised exercise alone after non-traumatic degenerative medial meniscal tear in older patients. (Herrlin, 2007).

Decision rationale: California ACOEM Guidelines that arthroscopy and meniscus surgery may not be equally beneficial for those patients who are exhibiting signs of degenerative changes. ACOEM also notes that there should be failure of an exercise program to increase range of motion and strength of the musculature around the knee. Official Disability Guidelines note that surgical intervention in the form of arthroscopy in individuals who have underlying moderate to severe degenerative change is not recommended. Documentation presented for review suggests the claimant has significant underlying osteoarthritis and has not attempted, failed or exhausted conservative treatment which should include antiinflammatories, home exercise program, formal physical therapy and consideration of intraarticular corticosteroid injections for diagnostic and

therapeutic intervention. In the setting of moderate to severe arthritis and considering surgical intervention in the form of arthroscopy, it would be medically reasonable to proceed with injection therapy in the form of intraarticular cortisone injections and also consideration of viscosupplementation prior to considering surgical intervention. Therefore, based on the documentation presented for review and in accordance with California ACOEM and Official Disability Guidelines, the request for the right knee arthroscopy, partial medical meniscectomy is not medically necessary.

Possible Patelloplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345; Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: The proposed right knee arthroscopy and partial medial meniscectomy is not recommended as medically necessary. The subsequent request for possible patelloplasty is also not medically necessary.

Possible Subcutaneous Lateral Release of the Retinaculum and Chondroplasty: 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 chapter, Chondroplasty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Chondroplasty Recommended as indicated below. Not recommended as a primary treatment for osteoarthritis, since arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical therapy and medical treatment. (Kirkley, 2008) See also Meniscectomy. ODG Indications for Surgery -- Chondroplasty: Criteria for chondroplasty (shaving or debridement of an articular surface), requiring ALL of the following: 1. Conservative Care: Medication. OR Physical therapy. PLUS 2. Subjective Clinical Findings: Joint pain. AND Swelling. PLUS 3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS 4. Imaging Clinical Findings: Chondral defect on MRI (Washington, 2003) (Hunt, 2002) (Janecki, 1998) Lateral retinacular release Recommended as indicated below. ODG Indications for Surgery -- Lateral retinacular release: Criteria for lateral retinacular release or patella tendon realignment or maquet procedure: 1. Conservative Care: Physical therapy (not required for acute patellar dislocation with associated intra-articular fracture). OR Medications. PLUS 2. Subjective Clinical Findings: Knee pain with sitting. OR Pain with patellar/femoral movement. OR Recurrent dislocations. PLUS 3. Objective Clinical Findings: Lateral tracking of the patella. OR Recurrent effusion. OR Patellar apprehension. OR Synovitis with or without crepitus. OR Increased Q angle >15 degrees. PLUS 4. Imaging Clinical Findings: Abnormal patellar tilt on: x-ray, computed tomography (CT), or MRI. (Washington, 2003) (Fithian, 2004) (Aderinto, 2002) (Naranja, 1996) (Radin, 1993).

Decision rationale: The proposed right knee arthroscopy and partial medial meniscectomy is not recommended as medically necessary. The subsequent request for possible patelloplasty is also not medically necessary.