

Case Number:	CM14-0090873		
Date Assigned:	08/01/2014	Date of Injury:	09/18/2005
Decision Date:	09/23/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/16/2014

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 Emergency Medicine and is licensed to practice in New York. 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 62-year-old male who was injured on September 18, 2005. The patient continued to experience bilateral knee pain, bilateral hip pain, and low back pain. Physical examination was notable for normal range of motion of the neck with pain, decreased range of motion of the lumbar spine with pain, tenderness over the bilateral lumbar paraspinal muscles, tenderness over the bilateral sacroiliac joints, positive straight leg raise test bilaterally, normal motor strength in the upper extremities, mildly decreased motor strength in the lower extremities bilaterally, bilateral knee effusions, and decreased range of motion to both knees. Diagnoses included post-laminectomy syndrome of the lumbar region, spinal stenosis, and osteoarthritis of the lower extremities. Treatment included Orthovisc injections of the knee bilaterally and medications. Requests for authorization for bilateral intra-articular injections with orthovisc #2, MRI scan bilateral knees, Lidoderm 5% # 60, Oxycontin 20 mg #30, Oxycontin 40 mg #60, and Trazodone 50 mg # 60 were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral intra-articular knee injections with Orthovisc series x2: Upheld

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

Decision rationale: Orthovisc is the viscosupplement hyaluronic acid. It is recommended as a possible option for severe osteoarthritis for patients who have not responded adequately to recommended conservative treatments (exercise, NSAIDs, or acetaminophen); to potentially delay total knee replacement, but in recent quality studies the magnitude of improvement appears modest at best. While osteoarthritis of the knee is a recommended indication, there is insufficient evidence for other conditions, including patellofemoral arthritis, chondromalacia patellae, osteochondritis dissecans, or patellofemoral syndrome (patellar knee pain). Hyaluronic acids are naturally occurring substances in the body's connective tissues that cushion and lubricate the joints. Intra-articular injection of hyaluronic acid can decrease symptoms of osteoarthritis of the knee; there are significant improvements in pain and functional outcomes with few adverse events. In this case, documentation does not support the diagnosis of severe osteoarthritis. There are no documented symptoms or radiologic evidence of severe osteoarthritis therefore, this request is not medically necessary.

MRI scan bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 334-335. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, MRI's (magnetic resonance imaging).

Decision rationale: Per MTUS MRI of the knee is indicated only for meniscus tear if surgery is being considered, ligament tears of the knee for confirmation, or patellar tendinitis if surgery is being considered. Per ODG indications for MRI of the knee are as follows: Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption. Nontraumatic knee pain, child, or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed.- Nontraumatic knee pain, child, or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary and if internal derangement is suspected.- Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected. Nontraumatic knee pain, adult - nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement. Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended In this case documentation state that the patient had prior MRI

of the left knee in 2009. The results are not available for review. The patient's had not suffered another knee injury and there was no documentation that there were significant changes in the patient's signs or symptoms. Medical necessity for MR of the bilateral knees is not supported therefore, this request is not medically necessary.

Lidoderm 5%, quantity :60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) Pain, Lidoderm (lidocaine patch) Page(s): 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Lidoderm® (lidocaine patch).

Decision rationale: Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. It is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. In this case, there is no evidence to support the presence or neuropathic pain. The patient is being treated for osteoarthritis of his knees. There are no dermatomal symptoms. Medical necessity has not been established therefore this request is not medically necessary.

Oxycontin, 20mg, 30 tabs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

Decision rationale: Oxycontin is the opioid medication, oxycodone. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDs have failed. In this case, the patient had been taking oxycontin since at least September 2013 and had not obtained analgesia. There is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use has not been met therefore this request are not medically necessary.

Oxycontin, 40mg, 60 tabs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

Decision rationale: Oxycontin is the opioid medication, oxycodone. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDs have failed. In this case, the patient had been taking Oxycontin since at least September 2013 and had not obtained analgesia. There is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met therefore, this request is not medically necessary.

Trazadone, 50mg, 60 tabs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-14.

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

Decision rationale: Trazodone is a tetracyclic antidepressant prescribed in this case for insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. Insomnia treatment should be based on etiology. Most medications have only been evaluated for short-term use (less than 4 weeks). Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Sedating antidepressants are often used to treat insomnia; however, there is less evidence to support their use for insomnia. They may be an option in patients with coexisting depression. Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Negative next-day effects such as ease of awakening may offset improvements in sleep onset. Tolerance may develop and rebound insomnia has been found after discontinuation. The patient has been taking this medication since at least September 2013. Increased duration of treatment increases the risk of tolerance and other adverse effects therefore, this request is not medically necessary.