

<b>Case Number:</b>	CM15-0108238		
<b>Date Assigned:</b>	06/12/2015	<b>Date of Injury:</b>	03/12/2014
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	05/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

### 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 injured worker was a 61-year-old female, who sustained an industrial injury, March 12, 2014. The injured worker previously received the following treatments right knee MRI left foot MRI on November 17, 2014 was negative, steroid injections in the knee, left foot injection, Ibuprofen, Diclofenac, Lidoderm patches and Amitriptyline. The injured worker was diagnosed with bilateral knee pain and left ankle and left foot pain and rule out left Morton's neuroma. According to progress note of May 15, 2015, the injured workers chief complaint was right knee pain and swelling. The injection into the left foot helped with the pain with less tingling and numbness with some movement of the toes. The physical assessment of the right knee was within normal limits with range of motion. There was tenderness over the medial joint line. The injured worker received a steroid injection in the right knee, which the injured worker reported helped, but was wearing off. The treatment plan included Hyalgan injection to the right knee set of three with ultrasound and prescriptions for Diclofenac and Lidocaine patches.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hyalgan injection to the right knee, set of 3, with ultrasound: 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), Knee and Leg Chapter (Online version).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-352. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Hyaluronic acid injections.

**Decision rationale:** MTUS is silent regarding the use of hyaluronic acid injections. While ACOEM guidelines do not specifically mention guidelines for usage of ultrasound guided hyaluronic acid injections, it does state that "Invasive techniques, such as needle aspiration of effusions or prepatellar bursal fluid and cortisone injections, are not routinely indicated. Knee aspirations carry inherent risks of subsequent intra-articular infection." ODG recommends as a guideline for Hyaluronic acid injections; "Patients experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative non-pharmacologic (e.g., exercise) and pharmacologic treatments or are intolerant of these therapies (e.g., gastrointestinal problems related to anti-inflammatory medications), after at least 3 months; Documented symptomatic severe osteoarthritis of the knee, which may include the following: Bony enlargement; Bony tenderness; Crepitus (noisy, grating sound) on active motion; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Over 50 years of age. Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; Failure to adequately respond to aspiration and injection of intra-articular steroids; The available medical record indicates that the IW underwent knee steroid injection and reported improvement, though it was now "wearing off." No other documentation provided comment on if the IW was unsuccessful with other non-pharmacologic treatment (such as physical therapy for knee) there is a statement that acupuncture was preferred to physical therapy, and effective. There is also no documentation regarding a diagnosis of osteoarthritis, which is the primary indication for the use of hyaluronic acid injections. As such, the request for Hyalgan injection to the right knee x3 is deemed not medically necessary.

**Diclofenac 100mg, #30 (prescribed 5/15/2015): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG, Pain Chapter (Online version).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Diclofenac.

**Decision rationale:** MTUS specifies four recommendations regarding NSAID use: 1) Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. 2) Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. 3) Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. 4) Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-

term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. The medical documents do not indicate that the patient is being treated for osteoarthritis. The treating physician does not document failure of primary (Tylenol) treatment. Importantly, ODG also states that diclofenac is "Not recommended as first line due to increased risk profile, if using diclofenac then consider discontinuing as it should only be used for the shortest duration possible in the lowest effective dose due to reported serious adverse events." Medical documents indicate that the IW was initially started on ibuprofen and switched to diclofenac directly without trial of other first line NSAID's. As such, the request for Diclofenac 100mg, #30 is deemed not medically necessary.

**Lidocaine patch 4%, #10 (prescribed 5/15/2015): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patches Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics.

**Decision rationale:** Per MTUS; "Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti- pruritics. For more information and references, see Topical analgesics. "ODG further details, "Criteria for use of Lidoderm patches: (a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued. " Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. Additionally, treatment notes did not detail other first- line therapy used and what the clinical outcomes resulted. As such, Lidocaine patch 4%, #10 patches is deemed not medically necessary.