

<b>Case Number:</b>	CM15-0108382		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	07/18/2010
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/22/2015
<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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 is a 64 year old male with an industrial injury dated 05/12/2011. His diagnosis is bilateral knee joint pain. Prior treatment included Supartz injection in 09/2014 (which did not help) and medications. He presents on 12/12/2014 with pain in right knee which is aggravated by walking and activity and relieved by frequent change in position and rest. Physical exam noted tenderness in right knee with normal range of motion. Muscle strength was normal. Gait was slightly antalgic. At the time of this visit the injured worker requested a steroid injection because previous Supartz injection didn't help him. He received Kenalog 60 mg and 3.5 ml of 1% plain lidocaine injection into the right knee. He was to continue his current medications, icing/heating, home exercise, massage and rest. The next progress note is dated 04/24/2015 which contains the following information: The injured worker presented with chronic bilateral knee pain which had increased recently. The plan of treatment is for bilateral knee Supartz injection times 3 (once weekly for 3 weeks), and Celebrex 200 mg as Naprosyn was not helping. The treatment request is for bilateral knee, Supartz injection 3 times (once weekly for 3 weeks) and Celebrex 200 mg quantity 30 with 2 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(Bilateral) Knee, Supartz injection 3 times (once wkly for 3 wks): 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 - Viscosupplementation; Hyaluronic acid injections.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, hyaluronic acid injections.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. Per the ODG section on leg and knee and hyaluronic acid injections, criteria for injections include patients who experience significantly symptomatic osteoarthritis without adequate response to conservative non-pharmacological and pharmacological treatments, documented symptomatic severe osteoarthritis of the knee, pain interferes with functional activities, failure to respond to aspiration and injection of intra-articular steroids, not candidates for total knee replacements and not indicated for any other indications. The patient does not have the diagnosis of moderate to severe proven osteoarthritis and therefore the request is not medically necessary.

**Celebrex 200 mg Qty 30 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines COX-2 NSAIDs; Celebrex. Decision based on Non-MTUS Citation Official Disability Guidelines: NSAIDs, GI symptoms and cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68-72.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID use and proton pump inhibitors (PPI) states: Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Cardiovascular disease: A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxen plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-

dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxen is ineffective, the suggested treatment is (1) the addition of aspirin to naproxen plus a PPI, or (2) a low-dose Cox-2 plus ASA. Cardiovascular risk does appear to extend to all non-aspirin NSAIDs, with the highest risk found for the Cox-2 agents. (Johnsen, 2005) (Lanas, 2006) (Antman, 2007) (Laine, 2007) Use with Aspirin for cardio protective effect: In terms of GI protective effect: The GI protective effect of Cox-2 agents is diminished in patients taking low-dose aspirin and a PPI may be required for those patients with GI risk factors. (Laine, 2007) In terms of the actual cardio protective effect of aspirin: Traditional NSAIDs (both ibuprofen and naproxen) appear to attenuate the antiplatelet effect of enteric-coated aspirin and should be taken 30 minutes after ASA or 8 hours before. (Antman, 2007) Cox-2 NSAIDs and diclofenac (a traditional NSAID) do not decrease anti-platelet effect. (Laine, 2007) Per the California MTUS guidelines, Cox-2 agents like Celebrex are indicated for patients at intermediate or high gastrointestinal risk. While the patient has had non-specific GI complaints, there are no documented risk factors that place the patient at intermediate or high risk as set forth above. Therefore the medication does not meet criteria and is not medically necessary.