

Case Number:	CM15-0011193		
Date Assigned:	01/29/2015	Date of Injury:	02/07/1998
Decision Date:	05/06/2015	UR Denial Date:	01/05/2015
Priority:	Standard	Application Received:	01/21/2015

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: Arizona, Michigan

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

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 65 year old female, who sustained an industrial injury on February 7, 1998. She reported bilateral shoulder and knee pain. The injured worker was diagnosed as having internal derangement of the knees bilaterally status post arthroscopy of the left knee, impingement syndrome bilaterally status post decompression with recent magnetic resonance imaging (MRI) in 2014, tendenosis, AC joint wear and chronic pain syndrome. Treatment to date has included radiographic imaging, diagnostic studies, left knee surgery, Hylagen injections to the right knee, orthotic braces to the bilateral knees, conservative therapies including hot and cold wraps and TENS unit use, medications and work restrictions. Currently, the injured worker complains of bilateral shoulder and knee pain. The injured worker reported an industrial injury in 1998, resulting in the above noted chronic pain. She has been treated conservatively and surgically without complete resolution of the pain. It was noted the injections to the right knee were temporarily beneficial and injection to the left knee was recommended. X-rays of the right and left knee were requested. Evaluation on January 16, 2015, revealed continued pain. The plan included adjusting and renewing medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Standing x-ray of right and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 336.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg (acute and chronic) / radiography.

Decision rationale: Per the MTUS, special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation once red flags are ruled out. Per the ODG, "Indications for imaging -- X-rays:- Acute trauma to the knee, fall or twisting injury, with one or more of following: focal tenderness, effusion, inability to bear weight. First study.- Acute trauma to the knee, injury to knee \geq 2 days ago, mechanism unknown. Focal patellar tenderness, effusion, able to walk.- Acute trauma to the knee, significant trauma (e.g, motor vehicle accident), suspect posterior knee dislocation.- Nontraumatic knee pain, child or adolescent - nonpatellofemoral symptoms. Mandatory minimal initial exam. Anteroposterior (standing or supine) & Lateral (routine or cross-table).- Nontraumatic knee pain, child or adult: patellofemoral (anterior) symptoms. Mandatory minimal initial exam. Anteroposterior (standing or supine), Lateral (routine or cross-table), & Axial (Merchant) view.- Nontraumatic knee pain, adult: nontrauma, nontumor, nonlocalized pain. Mandatory minimal initial exam. Anteroposterior (standing or supine) & Lateral (routine or cross-table). (ACR, 2001) (Pavlov, 2000)" A review of the injured worker medical records reveal that the injured worker has already had x-rays of the knees in the past year and there is no rationale given for repeating the x-rays, without this information medical necessity is not established and is not medically necessary.

Hyalgan injection to the knee: 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 and Leg Procedure Summary.

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 (acute and chronic) / hyaluronic acid injections.

Decision rationale: The MTUS / ACOEM 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. Per the ODG "Criteria 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;- Generally performed without fluoroscopic or ultrasound guidance;- Are not currently candidates for total knee replacement or who have failed previous knee surgery for their arthritis, unless younger patients wanting to delay total knee replacement. (Wen, 2000)- Repeat series of injections: If documented significant improvement in symptoms for 6 months or more, and symptoms recur, may be reasonable to do another series. No maximum established by high quality scientific evidence; see Repeat series of injections above.- Hyaluronic acid injections are not recommended for any other indications such as chondromalacia patellae, facet joint arthropathy, osteochondritis dissecans, or patellofemoral arthritis, patellofemoral syndrome (patellar knee pain), plantar nerve entrapment syndrome, or for use in joints other than the knee (e.g., ankle, carpo-metacarpal joint, elbow, hip, metatarsophalangeal joint, shoulder, and temporomandibular joint) because the effectiveness of hyaluronic acid injections for these indications has not been established."A review of the injured workers medical records reveal that she meets the criteria for hyaluronic acid injections, she has received hyaluronic acid injections in the past with documented improvement in symptoms, unfortunately, it is not clear from the request if this is for the left or right knee and without this information, medical necessity cannot be established and is not medically necessary.

LidoPro cream, 1 bottle: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 11-113.

Decision rationale: Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. A review of the injured workers medical records that are available to me does not show a trial of recommended first line agents that have failed therefore the request for LidoPro is not medically necessary.

Terocin patches #30: Upheld

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

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

Decision rationale: Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety.

They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. A review of the injured workers medical records that are available to me does not show a trial of recommended first line agents that have failed therefore the request for Terocin patches #30 is not medically necessary.

Celebrex: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and Cardiovascular risk Page(s): 67-69.

Decision rationale: Per the MTUS, NSAIDs and COX-2 NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors according to specific criteria listed in the MTUS and a selection should be made based on this. A review of the injured workers medical records indicate that she is at increased risk for gastrointestinal events due to her age, however the request does not specify a dose or treatment regimen and without this information medical necessity is not established and is not medically necessary.

Vicodin 75mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96 (78,89,95).

Decision rationale: Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management, actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to

improve pain and function. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long-term users of opioids should be regularly reassessed. In the maintenance phase, the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected. When this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. It is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. A review of the injured workers medical records does not show documentation that follows the recommended guidelines and without this information, medical necessity is not established and is not medically necessary.