

Case Number:	CM15-0052604		
Date Assigned:	03/26/2015	Date of Injury:	11/01/1984
Decision Date:	05/04/2015	UR Denial Date:	03/09/2015
Priority:	Standard	Application Received:	03/19/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 70 year old female who sustained a work related injury November 1, 1984. She slipped and fell, landing on her hands and knees, and noted pain in the bilateral knees within three days of the fall. Past history included hypertension, s/p right total knee surgery 1997, right knee arthroplasty, 2004, and revision, 2005. According to a primary treating physician's progress report, dated January 28, 2015, the injured worker presented with constant pain of the right knee described as aching which radiates up to the right hip, rated 10/10. There is constant pain of the left knee described as burning and aching, rated 8/10. Diagnoses included right knee degenerative joint disease (DJD), s/p TKA (total knee arthroplasty) x 3; left knee degenerative joint disease (DJD); left knee meniscus tear. Treatment plan included requests for referral for pain management, medications, follow-up as needed for future injections, and discussion regarding weight bearing as tolerated, full range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

(1) Prescription of Topical Lidopro cream: Upheld

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

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Lido Pro (capsaicin, menthol and methyl salicylate and lidocaine) contains capsaicin a topical analgesic and lidocaine not recommended by MTUS. There is no documentation of pain and functional improvement with previous use of Lido Pro. Based on the above Lido Pro cream is not medically necessary.

1 Follow up as needed for future injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cortisone injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Corticosteroid injections. <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, knee injection, recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. The beneficial effect could last for 3 to 4 weeks, but is unlikely to continue beyond that. Evidence supports short-term (up to two weeks) improvement in symptoms of osteoarthritis of the knee after intra-articular corticosteroid injection. The number of injections should be limited to three. (Leopold, 2003) (Arroll-BMJ, 2004) (Godwin, 2004) The short-term benefit of intra-articular (IA) corticosteroids in treatment of knee osteoarthritis is well established, and few side effects have been reported. Longer-term benefits have not been confirmed. Comparisons of IA corticosteroids showed triamcinolone hexacetonide was superior to betamethasone for number of patients reporting pain reduction up to four weeks post injection. Intra-articular injections of hyaluronate are associated with delayed onset of analgesia but a prolonged duration of action vs injections of corticosteroids. (Zhang, 2008) Intra-articular corticosteroid injections help to relieve pain and reduce swelling in osteoarthritis of the knee and typically yield improvement within 24 hours that lasts 4 to 8 weeks. Repeated injections to the knee may not accelerate disease progression for osteoarthritis. (Stephens, 2008) A meta-analysis of clinical trials concluded that, from baseline to week 4, intra-articular corticosteroids appear to be relatively more effective for pain than intra-articular hyaluronic acid, but by week 4, the 2 approaches have equal efficacy, and beyond week 8, hyaluronic acid has greater efficacy. (Bannuru, 2009) This study demonstrates the potential chondrotoxicity associated with intra-articular bupivacaine use in arthritic knee joints, particularly when given with a corticosteroid. Although these findings seem to be subtle and are probably subclinical after just 1 injection, they indicate the possible spectrum of iatrogenic injury

that may be caused by repeated injections of local anesthetics commonly used to treat articular pain. (Chu, 2010) Although there are several corticosteroid compounds available for use in the IA injection of the knee joint, there is scant comparative data for the compounds, although there appears to be a tendency for trimacinolone to be the most efficacious compound. Finally, IA injection of corticosteroid is a treatment adjunct and should not be used as monotherapy for patients with chronic, stable OA. (Douglas, 2012) This systematic review looking for predictors of response from intra-articular steroid injections in knee osteoarthritis suggested that absence of synovitis, presence of effusion, and withdrawal of fluid from the knee were all predictive of a better response. Increasing efficacy was also associated with increasing severity of radiographic degeneration and increasing severity of pain, stiffness, and loss of function. Duration of symptoms was not associated with response. (Maricar, 2013) An AHRQ meta-analysis of 137 studies with 33,243 participants concludes that hyaluronic acid was the best pharmacologic intervention for knee osteoarthritis, with an effect size of 0.63. For relieving pain, injections were more effective than oral treatments, and placebo injections were more effective than oral NSAIDs. The apparent superiority of intraarticular treatments may not reflect a placebo effect but, instead, relief from injecting any fluid into the joint space. For function, all interventions except injected corticosteroids were better than oral placebo. Hyaluronic acid was better than injected placebo or injected corticosteroids. (Bannuru, 2015) Criteria for Intraarticular glucocorticosteroid injections: Documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria, which requires knee pain and at least 5 of the following: (1) Bony enlargement; (2) Bony tenderness; (3) Crepitus (noisy, grating sound) on active motion; (4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; (5) Less than 30 minutes of morning stiffness; (6) No palpable warmth of synovium; (7) Over 50 years of age; (8) Rheumatoid factor less than 1:40 titer (agglutination method); (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm³); Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen); Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; Intended for short-term control of symptoms to resume conservative medical management or delay TKA; Generally performed without fluoroscopic or ultrasound guidance;- Absence of synovitis, presence of effusion preferred (not required); Aspiration of effusions preferred (not required); Only one injection should be scheduled to start, rather than a series of three;- A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option;- The number of injections should be limited to three. There is no documentation that the patient developed severe osteoarthritis or any of the conditions mentioned above. There is no documentation that the pain is causing limitation of the patient functional activity and activity of daily living. In addition, there is no documentation of functional improvement with the previous corticosteroid injection to the right knee. Therefore, the request for 1 Follow up as needed for future injection is not medically necessary.

Norco 5/325mg, Qty 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. According to the patient file, there is no objective documentation of pain and functional improvement to justify continuous use of Norco. Norco was used for longtime without documentation of functional improvement or evidence of return to work or improvement of activity of daily living. Therefore, the prescription of Norco 5/325mg #90 is not medically necessary.