

Case Number:	CM15-0082937		
Date Assigned:	05/05/2015	Date of Injury:	01/23/2007
Decision Date:	08/05/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	04/29/2015

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 York
 Certification(s)/Specialty: Anesthesiology

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 61 year old male, who sustained an industrial injury on 1/23/2007. He reported carrying a large object overhead and stepping on a pile of job material, causing his knee to bend laterally. The injured worker was diagnosed as having anterior cruciate ligament tear, bursitis of elbow, chronic intractable pain, elbow joint pain, knee pain, neuropathic pain of upper extremity, insomnia secondary to chronic pain, osteoarthritis of knee, and osteoarthritis of left elbow. Treatment to date has included left knee surgery in 2007 and conservative measures, including bracing, injections, transcutaneous electrical nerve stimulation unit, therapy, and medications. Currently (3/18/2015), the injured worker complains of left elbow and left knee pain. His left elbow pain was "horrible", with radiation down toward his left hand. Any weight bearing on the elbow was horrific and certain range of motion triggered a flare up. His left elbow pain was helped with injection in 1/2014 and topical gel. He was currently tolerating medications without side effects. Medications were documented as helping 60-70%, overall report of 80% improvement with the current regime, with improved pain, range of motion, and activities of daily living. He believed that Oxycodone was most helpful and agreed to gradually taper Norco. Current medications included Klonopin, Lidoderm patch, Lunesta, Norco, Oxycontin, Seroquel, Doxepin, Oxycodone, topical compound cream, and Montelukast. Urine toxicology (10/09/2014) was referenced as appropriate. His work status was "medically retired". Also noted on this date, was left knee pain, rated 8/10. He was documented as walking and fairly active, due to current medication regime. He was sleeping better with the use of Seroquel. Knee injections helped but they were not as effective as they used to be. He wanted a knee

injection if offered. A progress report dated 3/26/2015 noted treatment recommendation for first cortisone steroid injection for the left knee and a series of Hyalgan or Orthovisc injections. Also requested was an unloading brace, hot and cold wrap, transcutaneous electrical nerve stimulation unit with conductive garment (4 lead), Oxycontin, Oxycodone, Norco, Lidopro lotion, Flexaril, Effexor, Trazadone, Naproxen, and Protonix. The documentation supported chronic use of opioid analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cortisone injection and series of Hyalgan or Orthovisc injections, left 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 (ODG) Knee & Leg Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Corticosteroid injections Hyaluronic acid injections.

Decision rationale: According to the ODG, corticosteroid injections are recommended for short-term use only. An intra-articular corticosteroid injection results in a 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. Hyaluronic acid injections are 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. In this case, the patient has previously received a visco-supplement injection (Supartz) and 6 corticosteroid injections. There is no documentation of specific benefit or indication for additional injections. Medical necessity for the requested knee injections has not been established. The requested injections are not medically necessary.

Hot & cold wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: According to the CA MTUS/ACOEM guidelines, the home application of hot and cold packs is just as effective as those performed by a therapist. Cold packs decreased swelling. Hot packs had no beneficial effect on edema compared with placebo or cold application. There is no specific indication for the requested hot and cold wrap. Medical

necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

IF or muscle stimulator, conductive garment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ICS.

Decision rationale: According to MTUS, Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. The process involves paired electrodes of two independent circuits carry differing medium frequency alternating currents so that current flowing between each pair intersects at the underlying target. The frequency allows the Interferential wave to meet low impedance when crossing the skin. Treatments involve the use of two pairs of electrodes and most units allow variation in waveform, stimulus frequency and amplitude or intensity, and the currents rise and fall at different frequencies. Interferential current works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). In this case, there was no documentation of a decrease in subjective complaints, improvement in physical examination findings, an increase in functional abilities, or a reduction in medication use with the use of ICS. The requested unit is not indicated at this time. Medical necessity for the requested unit has not been established. The requested unit is not medically necessary.

Oxycontin 40mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the ODG and MTUS, Oxycodone (Oxycontin) is a long-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics. According to the ODG, chronic pain can have a mixed physiologic etiology of both that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment

should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no indication that long-term use of opiates has resulted in decreased pain levels or objective functional improvement. Medical necessity of the requested opioid analgesic has not been established. Of note, discontinuation of an Oxycontin should include a taper, to avoid withdrawal symptoms. The requested Oxycontin is not medically necessary.

Trazadone HCL 50mg #60 (Desyrel): Upheld

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

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

Decision rationale: Trazodone (Desyrel) is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. In this case, there is no documentation of a history of depression or anxiety. The patient is also maintained on Lunesta for treatment of insomnia. There is no specific indication for the use of Trazadone. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Cyclobenzaprine 7.5mg tab (Fexmid) #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. It is closely related to the tricyclic antidepressants. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. The medication has its greatest effect in the first four days of treatment. It is not recommended for the long-term treatment of chronic pain. In this case, there is no documentation of functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Lidopro ointment 121gm: 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: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the requested topical analgesic compound, LidoPro ointment, contains: Capsaicin, Lidocaine, Menthol and Methyl Salicylate. MTUS guidelines state that Lidocaine is not recommended for topical application for treatment of neuropathic pain. Capsaicin is recommended only as an option in patients who have not responded to or are intolerant to other treatments. In addition, there is no documentation that the already prescribed Gabapentin has failed in the treatment of pain relief to warrant this requested topical analgesic agent. Medical necessity for the requested topical analgesic compound has not been established. The requested topical compound is not medically necessary.

Pantoprazole 20mg #60 (Protonix): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Pantoprazole (Protonix), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Protonix has not been established. The requested medication is not medically necessary.

Venlafaxine ER 75mg #60 (Effexor): Upheld

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

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

Decision rationale: According to the ODG, Venlafaxine (Effexor) is recommended as an option in first-line treatment of neuropathic pain. Venlafaxine is a member of the selective serotonin

and norepinephrine reuptake inhibitors (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off-label recommended for the treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. It may have an advantage over tricyclic antidepressants due to lack of anticholinergic side effects. In this case, there is no documentation that the patient has neuropathic pain. There is no specific documentation indicating that use of this medication has resulted in any increased benefit in terms of pain control or any increased functional benefit. Of note, withdrawal effects can be severe. Abrupt discontinuation should be avoided and tapering is recommended before discontinuation. The requested medication is not medically necessary.

Oxycodone 30mg qid: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the ODG and MTUS, Oxycodone (Oxycontin) is a long-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. According to the ODG, chronic pain can have a mixed physiologic etiology of both that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional improvement from previous usage, or response to ongoing opiate therapy. Medical necessity of the requested opioid analgesic has not been established. Of note, discontinuation of an Oxycodone should include a taper, to avoid withdrawal symptoms. The requested Oxycontin is not medically necessary.

Norco 10/325mg qid: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include

current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.