

Case Number:	CM15-0083278		
Date Assigned:	05/05/2015	Date of Injury:	11/08/2010
Decision Date:	06/11/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	04/30/2015

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, Tennessee
 Certification(s)/Specialty: Emergency 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 61 year old female who sustained an industrial injury on 11/08/2010. Current impression includes severe degenerative joint disease of the left knee-rapidly progressive, and possible history of infection with prior surgery. Previous treatments were not included. Previous diagnostic studies submitted include laboratory evaluations. Report dated 03/02/2015 noted that the injured worker presented for follow up after blood work was completed. Blood work was noted to be normal, bone scan was not authorized, and no further signs of infection. It was noted that she has continued knee pain. Pain level was not included. Physical examination revealed antalgic gait on the left side, mild effusion, flexion deformity, and tricompartmental crepitus. X-rays revealed tricompartmental degenerative disease with chondrolysis. The treatment plan included request for pre-operative three-phase bone scan, and request for surgical intervention of the left total knee arthroplasty. Disputed treatments include Meloxicam, Norco, and 10 syringes of Lovenox.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 Tablets Of Meloxicam 15mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 67-68.

Decision rationale: Meloxicam is a nonsteroidal anti-inflammatory drug (NSAID). Chronic Medical Treatment Guidelines state that "anti-inflammatory drugs are the traditional first line of treatment, but long term use may not be warranted". For osteoarthritis it was recommended that the lowest dose for the shortest length of time be used. It was not shown to be more effective than acetaminophen, and had more adverse side effects. Adverse effects for GI toxicity and renal function have been reported. Medications for chronic pain usually provide temporary relief. Medications should be prescribed only one at a time and should show effect within 1-3 days. Record of pain and function with the medication should be documented. In this case, the patient had been receiving the medication for several months without relief. In this case, the meloxicam was requested as a part of postoperative treatment plan for total knee arthroplasty (TKA). The TKA was not authorized. Meloxicam is there for not medically necessary. The request should not be authorized.

Norco 10-325mg #100: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 11, 74-96.

Decision rationale: Norco is the compounded medication containing hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDs have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case the Norco was requested as a part of postoperative treatment plan for total knee arthroplasty (TKA). The TKA was not authorized. Norco is there for not medically necessary. The request should not be authorized.

10 Syringes of Lovenox 40mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/lovenox.html.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip & Pelvis, Prophylaxis (antibiotic & anticoagulant).

Decision rationale: Lovenox is enoxaparin, a low molecular weight heparin (LMWH) medication. One high quality meta-analysis concluded that low-molecular-weight heparin initiated in close proximity to surgery resulted in absolute risk reductions of 11% to 13% for deep vein thrombosis, corresponding to relative risk reductions of 43% to 55% compared with oral anticoagulants. Regarding extended LMWH prophylaxis, evidence shows consistent effectiveness and safety in the trials for venographic deep venous thrombosis and symptomatic venous thromboembolism. The need for extended out-of-hospital prophylaxis in patients undergoing hip arthroplasty surgery may be considered. Statistically, patients who undergo hip or knee replacement and receive short-duration anticoagulant prophylaxis, symptomatic nonfatal venous thromboembolism will occur in about 1 of 32 patients and fatal pulmonary embolism will occur in about 1 of 1000 patients within 3 months of the surgery. The best prophylactic agent in terms of both efficacy and safety was warfarin, followed by pneumatic compression, and the least effective and safe was low-dose heparin. Warfarin provided the lowest risk of both proximal deep venous thrombosis and symptomatic pulmonary embolism. In this case, the lovenox was requested as a part of postoperative treatment plan for total knee arthroplasty (TKA). The TKA was not authorized. Lovenox is there for not medically necessary. The request should not be authorized.