Case Number:	CM15-0087462		
Date Assigned:	05/11/2015	**Date of Injury:**	03/10/2015
Decision Date:	07/07/2015	**UR Denial Date:**	04/16/2015
Priority:	Standard	**Application Received:**	05/06/2015

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: Indiana
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 46 year old female, who sustained an industrial injury on 3/10/2015. She reported injury to her left shoulder and bilateral knees after falling. The injured worker was diagnosed as having rotator cuff rupture, tear medial meniscus of knee, tibial plateau fracture, shoulder joint pain, lower leg joint pain. Treatment to date has included medications, magnetic resonance imaging, x-rays. The request is for x-ray of the right knee, x-ray of the left knee, Diclofenac, wheelchair, and crutches. On 4/9/2015, she complained of left shoulder and bilateral knee pain. The records indicate that x-rays of the knees were completed on 3/10/2015, left knee magnetic resonance imaging completed on 3/15/2015, and right knee magnetic resonance imaging completed on 4/3/2015. She reported having had right knee surgery 30 years prior, and making a full recovery. The treatment plan included: retro authorization for x-ray of the left shoulder, and x-rays of bilateral knees, wheelchair, and Diclofenac.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 330-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Radiography.

Decision rationale: ACOEM states regarding knee evaluations, The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: Patient is able to walk without a limp. Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: Joint effusion within 24 hours of direct blow or fall. Palpable tenderness over fibular head or patella. Inability to walk (four steps) or bear weight immediately or within a week of the trauma. Inability to flex knee to 90 degrees. ODG states regarding radiograph of knee and leg, "Recommended. In a primary care setting, if a fracture is considered, patients should have radiographs if the Ottawa criteria are met. Among the 5 decision rules for deciding when to use plain films in knee fractures, the Ottawa knee rules (injury due to trauma and age >55 years, tenderness at the head of the fibula or the patella, inability to bear weight for 4 steps, or inability to flex the knee to 90 degrees) have the strongest supporting evidence." And further clarifies 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 >= 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). The medical records provided did not indicate a mechanism of injury of the knee that would meet ODG criteria. Additionally, the medical records indicate that the patient is able to ambulate, which supports not obtaining an x-ray per ACOEM. There is no further justification as to why an X-ray would aid in the diagnosis of this employee. Therefore, the request is not medically necessary.

X-ray of the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 330-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Radiography.

Decision rationale: ACOEM states regarding knee evaluations, The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical

parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: Patient is able to walk without a limp. Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: Joint effusion within 24 hours of direct blow or fall.- Palpable tenderness over fibular head or patella. Inability to walk (four steps) or bear weight immediately or within a week of the trauma. Inability to flex knee to 90 degrees. ODG states regarding radiograph of knee and leg, "Recommended. In a primary care setting, if a fracture is considered, patients should have radiographs if the Ottawa criteria are met. Among the 5 decision rules for deciding when to use plain films in knee fractures, the Ottawa knee rules (injury due to trauma and age >55 years, tenderness at the head of the fibula or the patella, inability to bear weight for 4 steps, or inability to flex the knee to 90 degrees) have the strongest supporting evidence." And further clarifies 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 >= 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).The medical records provided did not indicate a mechanism of injury of the knee that would meet ODG criteria. Additionally, the medical records indicate that the patient is able to ambulate, which supports not obtaining an x-ray per ACOEM. There is no further justification as to why an X-ray would aid in the diagnosis of this employee. Therefore, the request is not medically necessary.

Diclofenac 75mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints Page(s): 204, 330.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 63-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Diclofenac.

Decision rationale: MTUS specifies four recommendations regarding NSAID use: 1) Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. 2) Back Pain, Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective that acetaminophen for acute LBP. 3) Back Pain, Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and

acetaminophen but fewer effects than muscle relaxants and narcotic analgesics.4) Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. The medical documents do not indicate that the patient is being treated for osteoarthritis. The treating physician does not document failure of primary (Tylenol) treatment. Importantly, ODG also states that diclofenac is "Not recommended as first line due to increased risk profile. If using diclofenac then consider discontinuing as it should only be used for the shortest duration possible in the lowest effective dose due to reported serious adverse events." Medical documents indicate that the patient has been on diclofenac for at least several months, which given the treatment history does not appear to be the shortest duration possible. As such, the request is not medically necessary.

Wheelchair (rental or purchase): Overturned

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 and Leg, Wheelchair.

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

Decision rationale: Regarding wheelchairs, ODG states the following: "Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. Reclining back option recommended if the patient has a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day. Elevating legrest option recommended if the patient has a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or has significant edema of the lower extremities. Adjustable height armrest option recommended if the patient has a need for arm height different than that available using non-adjustable arms. A lightweight wheelchair is recommended if the patient cannot adequately self-propel (without being pushed) in a standard weight manual wheelchair, and the patient would be able to self-propel in the lightweight wheelchair." The employee meets the above criteria, so the request for a wheelchair is medically necessary.

Crutches: Overturned

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 and Leg, Crutches.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines; knee; walking aids.

Decision rationale: ODG states the following regarding crutches: "Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with

less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above." The employee meets the above criteria for crutches, so the request is medically necessary.