

Case Number:	CM14-0141007		
Date Assigned:	10/10/2014	Date of Injury:	08/16/1999
Decision Date:	11/10/2014	UR Denial Date:	08/23/2014
Priority:	Standard	Application Received:	09/02/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Acupuncture & Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

43y/o male injured worker with date of injury 8/16/99 with related low back and right knee pain. Per progress report dated 8/7/14, the injured worker rated his pain 9-10/10 without medications and as low as 4/10 with medications. The injured worker used a walking stick to aid ambulation. Per physical exam, straight leg raise test was positive on the right. The right knee was stable with varus/valgus stress tests and anterior/posterior drawer testing. The injured worker was status post two right knee surgeries and lumbar fusion surgery. Treatment to date has included TENS unit, physical therapy, surgery, synvisc injection, and medication management. The date of UR decision was 8/22/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synvisc injection right 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 & Leg (Acute and Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Hyaluronic Acid Injections

Decision rationale: The Claims Administrator based its decision on the Non-MTUS Official Disability Guidelines, Knee & Leg (Acute and Chronic). The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG) Knee & Leg, Hyaluronic Acid Injections. The Expert Reviewer's decision rationale: The MTUS is silent on the use of hyaluronic acid injections. Per ODG TWC with regard to viscosupplementation, 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. While osteoarthritis of the knee is a recommended indication, there is insufficient evidence for other conditions, including patellofemoral arthritis, chondromalacia patellae, osteochondritis dissecans, or patellofemoral syndrome (patellar knee pain)." Criteria for Hyaluronic acid injections: - Patients experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative nonpharmacologic (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. The documentation submitted for review indicates that the injured worker has previously received Synvisc injection to the right knee with only 3 months of relief. As the guideline criteria calls for 6 months or more of pain relief for repeat injections, the request is not medically necessary.

Zanaflex 4 mg #180: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Tizanidine (Zanaflex)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/antispasmodic drugs Page(s): 66.

Decision rationale: Per MTUS CPMTG p66 "Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One

study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain." With regard to muscle relaxants, the MTUS states: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement."The request is indicated for the injured worker's low back pain; however, #180 is excessive for trial of the medication. The documentation does not indicate that the injured worker has been treated with Zanaflex in the past, so supply should be limited to 6 weeks as all open comp cases need to be seen in 45 days. The request is not medically necessary.

Lunesta 2 mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS is silent on the treatment of insomnia. With regard to insomnia treatment, the ODG guidelines state "Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications for insomnia. This class of medications includes zolpidem (Ambien and Ambien CR), zaleplon (Sonata), and eszopicolone (Lunesta). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which mean they have potential for abuse and dependency. Although direct comparisons between benzodiazepines and the non-benzodiazepine hypnotics have not been studied, it appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and short duration of action."The documentation submitted for review do not contain information regarding sleep onset, sleep maintenance, sleep quality, and next-day functioning. It was not noted whether simple sleep hygiene methods were tried and failed. The request is not medically necessary.