

Case Number:	CM15-0013921		
Date Assigned:	02/02/2015	Date of Injury:	10/02/1984
Decision Date:	03/20/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/23/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 62 year old male, who sustained an industrial injury on 10/02/1984. The diagnoses have included bilateral knee arthritis, low back pain with degenerative disk disease and degenerative arthritis, and right foot drop. Treatments to date have included physical and aquatic therapy, orthovisc injections, home exercise program, ultraviolet light therapy, and medications. Diagnostics to date have included electromyography/nerve conduction studies on 01/29/2014 which showed chronic reinnervation changes in bilateral L5, S1 innervated muscles. In a progress note dated 05/07/2014, the injured worker presented with complaints of bilateral lower extremity cramping and low back pain that is relieved with aquatic therapy at the gym. The treating physician reported pending repeat orthovisc injections for injured worker. Utilization Review determination on 12/18/2014 non-certified the request for Right Knee Synvisc Injection, Ultram 50mg #90, Robaxin 750mg #60, and Biofreeze 3 roll-on per month citing Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral for right knee synvisc 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 (ODG), Knee & Leg - Hyaluronic acid injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-352, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Knee, Hyaluronic acid injections

Decision rationale: Orthovisc is a high molecular weight hyaluronan. MTUS is silent regarding the use of ultrasound guided orthovisc injections. While ACOEM guidelines do not specifically mention guidelines for usage of ultrasound guided orthovisc injections, it does state that Invasive techniques, such as needle aspiration of effusions or prepatellar bursal fluid and cortisone injections, are not routinely indicated. Knee aspirations carry inherent risks of subsequent intra-articular infection. ODG recommends as guideline 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; medical documents indicate that the patient had a series of synvisc injections in 2014. However, the treating physician did not document any functional improvement or reduction in pain from those injections. As such, the request for Referral for right knee synvisc injection is not medically necessary.

Ultram 50mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ultram Page(s): 74-96, 113, 123. Decision based on Non-MTUS Citation Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (Ultram®).

Decision rationale: Ultram is the brand name version of tramadol, which is classified as central acting synthetic opioids. MTUS states regarding tramadol that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. ODG further states, tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/acetaminophen. The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, the patient is 30 years post injury and there is no documentation provided

which discussed the setting of goals for the use of tramadol prior to the initiation of this medication. As such, the request for Ultram 50mg #90 is not medically necessary.

Robaxin 750mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: MTUS states regarding muscle relaxants, recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP and they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Medical documents also do not indicate what first-line options were attempted and the results of such treatments. Additionally, records do not indicate functional improvement with the use of this medication or other extenuating circumstances, which is necessary for medication usage in excess of guidelines recommendations. As such, the request for Robaxin 750mg #60 is not medically necessary.

Biofreeze, 3 roll-on per month: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Pain (Chronic) and Low Back, Topical Analgesics and Biofreeze

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." ACOEM and MTUS are silent regarding the use of camphor. ODG states in the low back chapter regarding biofreeze, recommended as an optional form of cryotherapy for acute pain. See also Cryotherapy, Cold/heat packs. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. (Zhang, 2008). Medical documents indicate that the patient is 30 years post injury. The treating physician does not

outline a trial and failure of first line therapies. As such, the request for Biofreeze, 3 roll-on per month is not medically necessary.