

<b>Case Number:</b>	CM15-0018215		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	10/19/2010
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

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

This 49 year old woman sustained an industrial injury on 10/19/2010 to her knee after banging it against a metal cabinet while sitting at her desk. Current diagnoses include sprains and strains of knee and leg, pain in joint of lower leg, thoracic and lumbosacral neuritis or radiculitis, lumbar disc displacement without myelopathy, and enthesopathy of the knee. Treatment has included oral medications and four sessions of physical therapy. Physician notes dated 1/14/2015 show reports of a 50% improvement after the last injection in her knee, however, the cold weather is reported to make the pain worse and she is now rating her pain 9/10. The physician notes the worker demonstrates adequate pain control and ability to function, however her goals indicate increasing the ability to function. Her plan includes refilling Norco and Pennsaid, weight loss program, urine sample on the next visit, and cortisone injection in the right knee. On 1/22/2015, Utilization Review evaluated prescriptions for a cortisone injection to the right knee and Pennsaid 2% two pumps to the bilateral knees twice per day, that were submitted on 1/27/2015. The UR physician noted no radiological evidence of osteoarthritis. Regarding the Pennsaid, there is no documentation that the worker is unable to tolerate oral medications. The MTUS, ACOEM Guidelines, (or ODG) was cited. The requests were denied and subsequently appealed to Independent Medical Review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cortisone injection for right knee:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339.

**Decision rationale:** The ACOEM chapter on knee complaints and injections states: 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 intraarticular infection. A reddened, hot, swollen area may be a sign of cellulitis or infected prepatellar bursitis; thus, aspirating the joint through such an area is not recommended because microorganisms may be introduced into a previously sterile joint space. If a patient has severe pain with motion, septic effusion of the knee joint is a possibility, and referral for aspiration, Gram stain, culture, sensitivity, and possibly lavage may be indicated. Initial atraumatic effusions without signs of infection may be aspirated for diagnostic purposes. There is a high rate of recurrence of effusions after aspiration, but the procedure may be worthwhile in cases of large effusions or if there is a question of infection in the bursa. Patients with recurrent effusions who have a history of gout or pseudogout may need aspiration to rule out infection, but more likely will need it only for comfort, if at all. Osteoarthritis can present with effusions, but findings of crepitus, palpable osteophytes, and history of chronic symptoms are usually sufficient to make the differential diagnosis. Swelling and sponginess anterior to the patella is consistent with a diagnosis of prepatellar bursitis. Cortisone injections are not routinely recommended per the ACOEM. This patient has the diagnosis of chronic knee pain. The patient continues to have pain despite other conservative measures for treatment. While not routinely recommended, cortisone injections do represent a treatment option. Therefore the request is certified.

**Pennsaid 2%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Topical NSAIDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

**Decision rationale:** The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic

receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) 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.

**Non-steroidal antiinflammatory agents (NSAIDs):** The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. (Biswal, 2006) These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) **Indications:** Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. **Neuropathic pain:** Not recommended as there is no evidence to support use. **FDA-approved agents:** **Voltaren Gel 1% (diclofenac):** Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. (Voltaren package insert) For additional adverse effects: See NSAIDs, GI symptoms and cardiovascular risk; & NSAIDs, hypertension and renal function. **Non FDA-approved agents:** **Ketoprofen:** This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. (Diaz, 2006) (Hindsen, 2006) Absorption of the drug depends on the base it is delivered in. (Gurol, 1996). Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. (Krummel 2000) Topical analgesic NSAID formulations are not indicated for long-term use and have little evidence for treatment of the spine, hip or shoulder. This patient has the diagnoses of chronic knee pain but not osteoarthritis. Therefore criteria for the use of topical NSAID therapy per the California MTUS have not been met and the request is not certified.