

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0113746 |                              |            |
| <b>Date Assigned:</b> | 06/22/2015   | <b>Date of Injury:</b>       | 01/09/1991 |
| <b>Decision Date:</b> | 07/28/2015   | <b>UR Denial Date:</b>       | 05/22/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/12/2015 |

### 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: Texas, California

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:

The injured worker is a 56 year old male, who sustained an industrial injury on 1/9/91. The injured worker has complaints of knees have become progressively more bothersome. The documentation noted that his pain continues to radiate from his low back through his buttocks and down his legs and radiate to the mid-back. There is numbness and tingling in his toes. The diagnoses have included chronic intractable pain syndrome; post laminectomy syndrome lumbar region and lumbar radiculopathy; low back pain, chronic and osteoarthritis. Treatment to date has included magnetic resonance imaging (MRI) and computerized tomography (CT) scan revealed disc protrusion at L5-S1 (sacroiliac); laminectomy on 6/26/95; left knee arthroscopy in 1998; caudal epidural, viscosupplementation injections for his knees; home exercise program; bilateral knee and lumbar magnetic resonance imaging (MRI) performed in 2000 revealed degenerative joint disease, thickening of right patellar tendon, partial medial meniscectomy; left knee and L5-S1 (sacroiliac) laminectomy; lumbar magnetic resonance imaging (MRI) in 2001 revealed left L4-5 disc protrusion and prior left sided laminectomy L5-S1 (sacroiliac) and epidural fibrosis; magnetic resonance imaging (MRI) of the knees were performed July 2012 revealed left moderate medial compartment osteoarthritis and degeneration posterior and mid medial meniscus, right knee moderate osteoarthritis with meniscal degeneration and post-surgical patellar tendon changes; electrodiagnostic study June 2012 revealed proximal nerve root abnormality bilaterally, greatest at L5 and S1 (sacroiliac) nerve roots with some lesser involvement of the L4 nerve roots; trazodone; fentanyl patch; ambien; lunesta; soma; oxycodone and clonazepam; narcotic pain medication; physical therapy; transcutaneous electrical nerve

stimulation unit and psychiatrist/psychologist. The request was for 10 bilateral knee supartz injections (#5 for each knee); oxycodone HCL 30mg #60 and fentanyl 75mcg/hour #10. Patient has received an unspecified number of PT visits for this injury. The medication list includes trazodone; fentanyl patch; ambien; lunesta; soma; oxycodone and clonazepam. Per note, dated 5/11/15 patient had complaints of pain in back, leg and knee with radiation, numbness and tingling at 6-9/10. Physical examination of the low back revealed tenderness on palpation, muscle spasm, decreased strength and sensation, positive SLR. Per note dated 6/4/15 physical examination of the knee revealed tenderness on palpation, 0-120 ROM and moderate crepitus. The patient's surgical history includes right patellar tendon repair in 1994, lumbar spine surgery in 1995, left knee arthroscopy in 1998, and left ankle surgery in 1981. Patient had received viscosupplementation injection for this injury. The patient has had MRI of knee in July 2012 that revealed osteoarthritis and meniscal degenerative changes. The patient has had a urine drug screen on 6/4/12 that was consistent. The patient has had MRI and CT scan of the lumbar spine that revealed disc protrusion. Patient has received an unspecified number of PT visits for this injury.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **10 Bilateral Knee Supartz Injections (#5 for Each Knee): Upheld**

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

**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 (updated 02/27/15) Hyaluronic acid injections.

**Decision rationale:** Request: 10 Bilateral Knee Supartz Injections #5 for Each Knee. California Medical Treatment Utilization Schedule (CA MTUS) Chronic Pain guidelines and American College of Occupational and Environmental Medicine(ACOEM), Occupational Medicine Practice Guidelines, 2nd Edition, does not address this request. Therefore, ODG guidelines are used. Per the ODG Guidelines, Hyaluronic acid or Hylan injection (Synvisc injection) are recommended in patients who, "Experience significantly symptomatic osteoarthritis but have not responded adequately to standard nonpharmacologic and pharmacologic treatments or are intolerant of these therapies (e.g., gastrointestinal problems related to anti-inflammatory medications); Are not candidates for total knee replacement or who have failed previous knee surgery for their arthritis, such as arthroscopic debridement; Younger patients wanting to delay total knee replacement." Patient has received an unspecified number of PT visits for this injury. Previous conservative therapy notes were not specified in the records provided. The records provided did not specify response to standard non-pharmacologic and pharmacologic treatments. Any evidence of intolerance to standard non pharmacologic and pharmacologic treatments (e.g., gastrointestinal problems related to anti-inflammatory medications) was not specified in the records provided. Patient had received viscosupplementation injection for this injury. The detailed response to the previous viscosupplementation injection was not specified in the records provided. The medical necessity of the request for 10 Bilateral Knee Supartz Injections #5 for Each Knee is not fully established in this patient.

**Oxycodone HCL 30 MG #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines -Opioids, criteria for use: page 76-80 CRITERIA FOR USE OF OPIOIDS Therapeutic Trial of Opioids.

**Decision rationale:** Oxycodone HCL 30 MG #60, Oxycodone is an opioid analgesic According to CA MTUS guidelines cited below, "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." The records provided do not specify that patient has set goals regarding the use of opioid analgesic. A treatment failure with non-opioid analgesics is not specified in the records provided. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of the overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." The records provided do not provide a documentation of response in regards to pain control and functional improvement to opioid analgesic for this patient. The continued review of overall situation with regard to nonopioid means of pain control is not documented in the records provided. As recommended by MTUS a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. The level of pain control with lower potency opioids (like tramadol) and other non opioid medications (antidepressants/ anticonvulsants), without the use of Oxycodone , was not specified in the records provided. Whether improvement in pain translated into objective functional improvement, including ability to work is not specified in the records provided With this, it is deemed that, this patient does not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Oxycodone HCL 30 MG #60 is not established for this patient, given the records submitted and the guidelines referenced. If this medication is discontinued, the medication should be tapered, according to the discretion of the treating provider, to prevent withdrawal symptoms.

**Fentanyl 75 MCG/HR #10: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines -Opioids, criteria for use: page 75-80 Duragesic (fentanyl transdermal system) page 44, Fentanyl page47.

**Decision rationale:** According to MTUS guidelines Duragesic "is an opioid analgesic with potency eighty times that of morphine. Weaker opioids are less likely to produce adverse effects than stronger opioids such as fentanyl." According to MTUS guidelines Duragesic is "not recommended as a first-line therapy. The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means." In addition, according to CA MTUS guidelines cited below, "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." The records provided do not specify that that patient has set goals regarding the use of opioid analgesic. A treatment failure with non-opioid analgesics is not specified in the records provided. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." The records provided do not provide a documentation of response in regards to pain control and functional improvement to opioid analgesic for this patient. The continued review of overall situation with regard to non-opioid means of pain control is not documented in the records provided. As recommended by MTUS a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. MTUS guidelines also recommend urine drug screen to assess for the use or the presence of illegal drugs in patients using opioids for long term. A recent urine drug screen report is not specified in the records provided. With this, it is deemed that, based on the clinical information submitted for this review and the peer reviewed guidelines referenced, this patient does not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Fentanyl 75 MCG/HR #10 is not established for this patient.