

Case Number:	CM15-0116747		
Date Assigned:	06/24/2015	Date of Injury:	08/30/2006
Decision Date:	09/18/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/16/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 is a 58-year-old female with an August 30, 2006 date of injury. A progress note dated May 6, 2015 documents subjective complaints (right knee pain rated at a level of 4/10 that increases to 6-7/10 with colder weather or prolonged walking during household chores; activity limited secondary to pain; stiffness of the left knee joint; pain at the front of the knee which radiates to the medial and lateral aspects of the knee cap; pain is increased in cold weather; occasional buckling of the left knee; left knee pain rated at a level of 3/10; difficulty sleeping secondary to pain), objective findings (decreased range of motion of the bilateral knees; tenderness to palpation along the right medial patella facet; positive patellar grind bilaterally; tenderness to palpation over the left medial joint line, lateral joint line, and medial patellar facet; pain with left knee range of motion; positive Mc Murray and Lachman on the left knee) and current diagnoses (left knee degenerative joint disease; left knee possible anterior cruciate ligament tear; left knee patellofemoral syndrome; bilateral chondromalacia). Treatments to date have included acupuncture and chiropractic treatments for the neck, arm, and back, Orthovisc injections of the knees which provided good relief for about nine months to a year, medications, activity modifications, and physical therapy. The medical record indicates that the injured worker has a history of rectal bleeding. The treating physician documented a plan of care that included bilateral Orthovisc injection series (three injections for each knee), CM3-Ketoprofen compound, Lidoderm patches, Vicodin, and Ondansetron.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Orthovisc injections series (3 injections each 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 & Chronic): Hyaluronic acid injections (2015).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-352. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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 intraarticular infection." ODG recommends as guideline for Hyaluronic acid injections "Patients experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative non-pharmacologic (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." ODG states that "This RCT found there was no benefit of hyaluronic acid injection after knee arthroscopic meniscectomy in the first 6 weeks after surgery, and concluded that routine use of HA after knee arthroscopy cannot be recommended." Additionally, ODG states that Hyaluronic acid injections "Generally performed without fluoroscopic or ultrasound guidance." The medical records fail to fulfill the indications for Orthovisc and there is no documentation of failure of steroids. As such, the request for Bilateral Orthovisc injections series (3 injections each knee) is not medically necessary.

1 prescription CM3-Ketoprofen 20%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

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 anti-convulsants have failed. The medical documents do not indicate failure of antidepressants or anti-convulsants. 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." KETOPROFEN (NOT RECOMMENDED). Per ODG and MTUS, Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis and

photosensitization reactions. As such, the request for topical 1 prescriptions CM3-Ketoprofen 20% is not medically necessary.

1 prescription Lidoderm patch 5%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics and Other Medical Treatment Guidelines UpToDate.com, Lidocaine (topical).

Decision rationale: Chronic Pain Medical Treatment Guidelines state "Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical analgesics."ODG further details, criteria for use of Lidoderm patches: (a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued. Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. Additionally, treatment notes did not detail other first-line therapy used and what the clinical outcomes resulted. As such, the request for 1 prescription Lidoderm 5% patch is not medically necessary.

1 prescription Vicodin 5/300mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Opioids.

Decision rationale: Vicodin is the brand name version of hydrocodone and acetaminophen, which is considered a short-acting opioid. ODG does not recommend the use of opioids for shoulder pain except for short use for severe cases, not to exceed 2 weeks. The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The medical records fail to document the intensity of pain after taking opioid, pain relief, increased level of function, improved quality of life, or other objective and functional outcomes, which is necessary for continued ongoing use of opioids. As such, the request for 1 prescription Vicodin 5/300mg is not medically necessary.

1 prescription Ondansetron 4mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants, NSAIDs, GI symptoms, opioids Page(s): 68-69, 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Anti-emetics (for opioid nausea).

Decision rationale: Ondansetron (Zofran) is an anti-emetic used to decrease nausea and vomiting. Nausea is a known side effect of chronic opioid use and some Serotonin norepinephrine reuptake inhibitors (SNRIs). ODG does not recommend use of anti-emetic for nausea and vomiting secondary to chronic opioid use. Additionally, "This drug is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use." There is no evidence that patient is undergoing chemotherapy/radiation treatment or postoperative. MTUS is specific regarding the gastrointestinal symptoms related to NSAID usage. If criteria are met, the first line treatment is to discontinue usage of NSAID, switch NSAID, or consider usage of proton pump inhibitor. There is no documentation provided that indicated the discontinuation of NSAID or switching of NSAID occurred. Additionally, ondansetron is not a proton pump inhibitor and is not considered first line treatment. As such the request for 1 prescription Ondansetron 4mg is not medically necessary.