

<b>Case Number:</b>	CM15-0142614		
<b>Date Assigned:</b>	08/26/2015	<b>Date of Injury:</b>	06/13/2009
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 33 year old female who sustained an industrial injury on 06-13-2009. She reported injury to the left knee that resulted from a fall. Treatment to date has included medications, surgery, cortisone injection and physical therapy. According to a progress report dated 06-01-2015, pain was intermittent. Swelling was noted. In regard to activities of daily living, she did some laundry. She was not doing any mopping, dusting or sweeping. She had quite a bit of pain with a little activity that she did towards the end of the day associated with swelling. She could sit for 30 minutes, stand and walk for 30 minutes and lift possibly 20 pounds. She had buckling, locking and almost fell in the past. She had gained 40 pounds from this injury. Her most recent 10-panel urine drug screen was negative for narcotics in December 2014. She had been out of narcotics for the last four weeks. The provider noted that a second urine screen done in February was positive. Therefore he was going to provide Norco. Diagnoses included left knee pain with anterior cruciate ligament tear as well as intraosseous cyst as well as anterior horn tear of the lateral meniscus, status post arthroscopy, chronic right ankle ATFL sprain and an element of sleep, stress and depression due to chronic pain and inactivity. Treatment recommendations included Nalfon, Trazodone, Effexor, Norco, Protonix and Aciphex, psychiatry and group therapy sessions, ten-panel urine screen four lead TENS unit with conductive garment, Richie ankle brace and water therapy. A cortisone injection to the knee was recommended on return visit. X-rays revealed a 2 millimeter articular surface on semi-squatted position. In regards to work status, the provider noted that the injured worker could do intermittent sitting, standing and walking, no squatting, no forceful activities, no inclines or hills. Currently under review is the request for Nalfon 400 mg #60, AcipHex 20 mg #30, 1 ten panel urine screen, 12 aqua therapy sessions and 1 cortisone injection or Hyalgan injection to the knee. Urine drug screens were not submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Nalfon 400mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Non-steroidal Anti-inflammatory Drugs (NSAIDs).

**Decision rationale:** Fenoprofen calcium (Nalfon) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. According to the California MTUS Guidelines, NSAIDs reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), short-term pain relief and improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain. Current evidence-based guidelines indicate that Fenoprofen is less effective and has greater side effects than Naproxen or Ibuprofen. Guidelines indicate that Fenoprofen should not be used unless there is a sound medical basis for not using a safer or more effective alternative NSAID. In this case, documentation shows long term use of Nalfon. There is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. There was no rationale provided which explained the request for Nalfon. Medical necessity of the requested medication has not been established. The requested item is not medically necessary.

**AcipHex 20mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Proton Pump Inhibitors.

**Decision rationale:** According to CA MTUS (2009), proton pump inhibitors, such as Aciphex (Rabeprazole), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. According to the ODG, a trial of omeprazole or lansoprazole had been recommended before prescription Nexium therapy (until it went OTC). Other PPIs, such as Aciphex, would be considered second-line. In this case, documentation shows long term use of proton pump inhibitors. In February 2015, the injured worker was prescribed Protonix for upset

stomach. The efficacy of this treatment was not discussed. There was no discussion as to why the injured worker was unable to take a first-line proton pump inhibitor. Therefore, the medical necessity of this requested medication has not been established. The requested medication is not medically necessary.

### **1 Ten panel urine screen: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing, Opioids, screening for risk of addiction (tests). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Urine Drug Testing (UDT).

**Decision rationale:** According to the CA MTUS, drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. The CA MTUS Guidelines recommend use of drug screening or inpatient treatment with issues of abuse, addiction or poor pain control. According to the ODG, urine drug testing (UDT) is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. UDT is not generally recommended in an acute treatment setting (i.e. when opioids are required for nociceptive pain). It is recommended in cases in which the patient asks for a specific drug, particularly if the drug has high abuse potential, the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic substitution. UDT is recommended if the patient has a positive or "at risk" addiction screen on evaluation and if aberrant behavior or misuse is suspected and/or detected. For ongoing-monitoring UDT is recommended if a patient has evidence of a "high risk" of addiction (including evidence of a comorbid psychiatric disorder (such as depression, anxiety, attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, and/or schizophrenia), has a history of aberrant behavior, personal or family history of substance dependence (addiction), or a personal history of sexual or physical trauma, ongoing urine drug testing is indicated as an adjunct to monitoring along with clinical exams and pill counts. If dose increases are not decreasing pain and increasing function, consideration of urine drug testing should be made to aid in evaluating medication compliance and adherence. In this case, documentation shows long term use of opioids. In December, 2014, a urine drug screen was negative for narcotics. The provider noted that a second urine drug screen in February was positive. These drug screens were not submitted for review. There is no indication of why a 10 panel urine drug screen was being requested four months later. Medical necessity for the requested service has not been established. The requested urine testing is not medically necessary.

### **12 Aqua therapy sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004, and Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Aquatic therapy.

**Decision rationale:** According to CA MTUS Guidelines (2009), aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to

land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight-bearing is desirable (for example, extreme obesity). Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. In this case, there is limited documentation of significant objective and functional deficits in the physical exam to support the need for reduced weight-bearing in order to progress with therapy. In addition, the documentation did not indicate that the patient was severely obese or indicate that he had difficulty ambulating without assistance. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

### **1 Cortisone injection or hyalgan injection to 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 (Hyaluronic acid injections) (2015).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hyalgen Injections, Corticosteroid injections.

**Decision rationale:** According to the ODG, Hyalgen 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. The ODG states that corticosteroid injections, are recommended for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. The beneficial effect could last for 3 to 4 weeks, but is unlikely to continue beyond that. Evidence supports short-term (up to two weeks) improvement in symptoms of osteoarthritis of the knee after intra-articular corticosteroid injection. The number of injections should be limited to three. The short-term benefit of intra-articular (IA) corticosteroids in treatment of knee osteoarthritis is well established, and few side effects have been reported. Longer-term benefits have not been confirmed. In this case, there is no indication that the patient has osteoarthritis of the knee. She was diagnosed with an anterior cruciate ligament tear, an intraosseous cyst, and a lateral meniscus tear of the left knee. Medical necessity for the requested injections has not been established. The requested injection(s) are not medically necessary.