

Case Number:	CM15-0022146		
Date Assigned:	02/11/2015	Date of Injury:	12/31/2003
Decision Date:	04/14/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/05/2015

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: District of Columbia, Virginia
 Certification(s)/Specialty: Internal Medicine

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 43 year old female, who sustained an industrial injury on 12/31/2003. The diagnoses have included joint pain lower leg and ankle, osteoarthritis lower leg, left knee chondromalacia patella and tear of medial cartilage or meniscus of knee. Treatment to date has included Euflexxa injections for the left knee and medication. According to the progress note dated 1/15/2015, the injured worker complained of left knee pain. She reported having increased pain and discomfort of her left medial knee in the last few weeks. She reported that her knee brace was working well. She noted that the last Euflexxa injection gave her six months of relief from knee pain. Objective findings revealed mild medial joint line pain. The treatment plan was to refill Arthrotec and Amitriptyline and for a Neoprene knee brace. On 1/30/2015, Utilization Review (UR) non-certified a request for Arthrotec 75mg/200mg #60 and a Neoprene Knee Brace. The Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) Guidelines and Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Arthrotec 75mg/200mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs ,GI Symptoms &Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792
Page(s): 70.

Decision rationale: Per MTUS: Combination (NSAID/GI protectant): Arthrotec (diclofenac/misoprostol) 50mg/200mcg, 75mg/20mcg. [Black Box Warning]: Do not administer Arthrotec/misoprostol to pregnantwomen because it can cause abortion. Mechanism of action: Combines a diclofenac (an NSAID) with misoprostol, an agent that inhibits basal and nocturnal gastric acid secretion and has somemucosal protective properties. Misoprostol is available as Cytotec. Uses: Indicated for thetreatment of the signs and symptoms of osteoarthritis in patients at high risk for developing NSAID-induced gastric or duodenal ulcers and their complications. These two products areavailable as separate medications if you need to individualize therapy. Side Effects: See diclofenac. Misoprostol side effects: (vs. diclofenac alone). The following symptoms were increased over and above that found for diclofenac alone with the addition of misoprostol: Abdominal pain (21% with Arthrotec and 15% with diclofenac); Diarrhea (19% with Arthrotecv. 11% with diclofenac); Dyspepsia (14% for Arthrotec vs. 11% for diclofenac);Nausea/vomiting (11% for Arthrotec vs. 6% for diclofenac); Flatulence (9% for Arthrotec vs. 4%for diclofenac). Diarrhea and abdominal pain usually resolve in 2 to 7 days. Dosing: Therecommended dose for OA is diclofenac 50mg/misoprostol 200mcg t.i.d. In patients that may not tolerate this dose, 50mg/200mcg b.i.d and 75mg/200mcg b.i.d. may be prescribed, but aresomewhat less effective in ulcer prevention. (Arthrotec Package Insert) (Bocanegra, 1998) Long term usage of this medication would not be indicated. The patient had been taking this medication without any documentation of improvement of symptoms. Further administration of this medication would not be indicated.

1 Neoprene knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee &Leg (Acute&Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 304.

Decision rationale: Per MTUS and ACOEM: A knee brace can be used for patellar instability, ACL tear, or MCL instability although its benefits may be more emotional (i.e. increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually not necessary. In all case, the braces need to be properly fitted and combined with a rehabilitation. Criteria for the use of knee braces Pre-fabricated kneed braces may be appropriate in patients with one of the following condition: 1. Knee instability; 2. Ligament insufficiency/deficiency; 3. Reconstructed ligament; 4. Articular defect repair; 5. Avascular necrosis; 6. Meniscus cartilage repair; 7. Painful failed total knee arthroplasty; 8. Painful unicompartmental osteoarthritis; 9. Painful high tibial osteotomy; 10. Tibial plateau

fracture. Custom-fabricated knee braces may be appropriate for patients with the following conditions which may preclude the use of a prefabricated model: 1. Abnormal limb contour such as: a. Valgus (knock kneed) limb. b. Varus (bow legged) limb. c. Tibial varum. d. Disproportionate thigh and calf (ef chronic steroid use). e. Minimal muscle mass on which to suspend a brace. 2. Skin changes such as: a. Excessive redundant soft skin. b. Thin skin with risk of breakdown (ef large thigh and small calf). c. Minimal muscle mass on which to suspend a brace. 3. Severe osteoarthritis (grade 3 or 4). 4. Maximal off loading of painful or repaired knee compartment (example: heavy patient, significant pain). 5. Severe instability as noted on physical examination of knee. The patient is obtaining relief from her current brace, as per review of the clinical data. An additional brace would not be indicated.