

Case Number:	CM15-0068899		
Date Assigned:	04/21/2015	Date of Injury:	02/08/2008
Decision Date:	05/19/2015	UR Denial Date:	03/23/2015
Priority:	Standard	Application Received:	04/10/2015

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:

This is a 62 year old female patient, who sustained an industrial injury on 2/8/2008. Diagnoses have included lumbar spondylosis and bilateral knee osteoarthopathy. According to the progress report dated 2/12/2015, she had complaints of left knee pain at 7/10, right knee pain at 6/10, low back pain at 7/10 with left lower extremity symptoms and right shoulder pain at 8/10. Physical examination revealed Lumbar spine- tenderness with paraspinal spasm, flexion 50, extension 20 and lateral tilt right/left 20 degrees; left and right knee- range of motion- 0 to 120 degrees, painful patellofemoral crepitanace. The medications list includes hydrocodone and naproxen. Prior diagnostic study reports were not specified in the records provided. Treatment to date has included transcutaneous electrical nerve stimulation (TENS) and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10mg QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management, Opioids Page(s): 80-81, 94-95. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers Compensation, 5th Edition, 2007, Pain (Chronic), Weaning, opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-80.

Decision rationale: Hydrocodone 10mg QTY: 60. Hydrocodone is an opioid analgesic. According to the cited guidelines, 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. The 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 non-opioid 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 objective functional improvement to opioid analgesic for this patient. The continued review of the overall situation with regard to non-opioid means of pain control is not documented in the records provided. As recommended by the cited guidelines 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. A recent urine drug screen report is not specified in the records provided. This patient does not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Hydrocodone 10mg QTY: 60 is not established for this patient.

Viscosupplementation Left Knee (Series) QTY: 3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Guidelines, 16th Edition (2011 web), Knee Section, Hyaluronic Acid Injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Knee & Leg(updated 05/05/15)Hyaluronic acid injections.

Decision rationale: Viscosupplementation Left Knee (Series) QTY: 3ACOEM and CA MTUS do not address this request. Per the ODG Guidelines Criteria 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. Diagnostic reports of the left knee demonstrating severe osteoarthritis is not specified in the records provided. Response to previous conservative/non operative therapy for the left knee is not specified in the records provided. Any intolerance or lack of response to standard oral pharmacologic treatment (NSAIDs) is not specified in the records provided. The medical necessity of

viscosupplementation Left Knee (Series) QTY: 3 is not established in this patient at this time. Therefore is not medically necessary.

MRI of the Right Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

Decision rationale: MRI of the Right Shoulder. According to ACOEM guidelines cited below, for most patients, special studies are not needed unless a three or four week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red flag conditions are ruled out. Criteria for ordering imaging studies are: Emergence of a red flag; e.g., indications of intra abdominal or cardiac problems presenting as shoulder problems; Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Reynaud's phenomenon); Failure to progress in a strengthening program intended to avoid surgery.; Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). Physiologic evidence of significant tissue insult or neurovascular dysfunction are not specified in the records provided. Per the records provided, patient does not have any evidence of red flag signs such as possible fracture, infection, tumor or possible cervical cord compromise. The records provided did not indicate that surgical interventions were being considered. Response to a full course of conservative therapy including physical therapy for the right shoulder is not specified in the records provided. The medical necessity of MRI of the right shoulder is not established for this patient. Therefore is not medically necessary.