

<b>Case Number:</b>	CM13-0041268		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	04/27/2004
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 74 year old male, with a reported date of injury on 04/27/2004. The mechanism of injury was reportedly caused from lifting. The injured worker's diagnoses included lumbar/lumbosacral disc degeneration, chronic low back pain and osteoarthritis of the left knee. Previous treatments included physical therapy and pain medication. Diagnostic studies included MRI of spine without contrast on 06/21/2004 and bilateral knee x-ray on 04/24/2013. The pertinent surgical history was not provided within the documentation available. The injured worker complained of pain, rated at 6-7/10 in his left knee. The physical exam findings on 10/21/2013 regarding left knee were active range of motion 0-100 degrees and motor strength rated at 5/5. The Lumbar spine active range of motion was noted to be limited by 25% in all planes of movement. The medication regimen included Lidoderm 5% patch and Celebrex 200mg. The treatment plan included synvisc injections for left knee and lumbar epidural steroid injection. The Rationale for request was not provided. The request for authorization for left L5-S1 Epidural steroid injection; physical therapy 2 times a week for 6 weeks for low back and left knee; and unloader brace for the left knee was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LEFT L5-S1 EPIDURAL STEROID INJECTION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back Chapter, Epidural steroid injections

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** The request for left L5-S1 epidural steroid injection is not medically necessary. The California MTUS guidelines recommend that in order to obtain epidural steroid injections, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Epidural glucocorticosteroid injections are not recommended for treatment of acute, subacute, or chronic low back pain in the absence of significant radicular symptoms. The clinical information provided for review does not provide documentation related to conservative treatment, and the subsequent failure. In addition, there is a lack radiculopathy being corroborated by physical exam and imaging studies or electrodiagnostic testing. Therefore, the request is not medically necessary.

**PHYSICAL THERAPY 2 TIMES A WEEK FOR 6 WEEKS FOR LOW BACK AND LEFT KNEE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM OCCUPATIONAL MEDICINE PRACTICE GUIDELINES, 2ND EDITION, 2004, PAIN, SUFFERING, AND THE RESTORATION OF FUNCTION CHAPTER, 114 Official Disability Guidelines (ODG), Knee and Leg and Low Back Chapters, (<http://www.odg-twc.com/preface.htm#PhysicalTherapyGuidelines>)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Physical Medicine Page(s): 98-99.

**Decision rationale:** The request for physical therapy 2 times a week for 6 weeks for low back and left knee is not medically necessary. The California MTUS guidelines recommend to allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. The guidelines recommend 8-10 physical therapy sessions. The clinical information provided for review lacks documentation related to the functional deficits, to include range of motion in degrees and the illustration of pain utilizing a VAS pain scale. There is a lack of documentation of the therapeutic or functional benefit provided from previous physical therapy. In addition, the request for 12 physical therapy sessions exceeds the recommended guidelines. Therefore, the request for physical therapy 2 times a week for 6 weeks for low back and left knee is not medically necessary.

**UNLOADER BRACE FOR THE LEFT 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 (ODG), Knee and Leg Chapter

**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, Unloader braces for the knee.

**Decision rationale:** The request for unloader brace for the left knee is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines do not address this request. The Officially Disability Guidelines recommend unloader braces are designed to reduce the pain and disability associated with osteoarthritis of the medial compartment of the knee by bracing the knee in the valgus position in order to unload the compressive forces on the medial compartment. The injured worker has a history of left knee pain related to osteoarthritis, with no surgical history. The clinical information indicates the injured worker previously participated in physical therapy, there is a lack of documentation related to the functional or therapeutic benefit. There is a lack of documentation associated with the functional deficits, to include the need to unload the compressive forces from the medial compartment. In addition, the clinical information indicates the injured worker utilizes a knee brace 2 hours per day at home. There is a lack of documentation that the current knee brace being utilized is worn or in need of replacement. Therefore, the request for unloader brace for the left knee is not medically necessary.