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| <b>Case Number:</b>   | CM14-0064252 |                              |            |
| <b>Date Assigned:</b> | 07/11/2014   | <b>Date of Injury:</b>       | 06/01/2009 |
| <b>Decision Date:</b> | 09/17/2014   | <b>UR Denial Date:</b>       | 04/29/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/07/2014 |

### 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 Family Medicine and is licensed to practice in California. 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:

This is a male patient who reported an industrial injury on 6/1/2009, over 5 years ago, attributed to the performance of his customary job tasks. The patient was treated for shoulder joint pain; lower leg pain; ankle/foot joint pain; SI (sacroiliac) spine strain; lumbar DDD (degenerative disc disease); postlaminectomy syndrome. The patient complains of lower back and left knee pain. The patient reportedly underwent a lumbar spine ESI (epidural steroid injection) which resulted in 50% pain relief. The patient had continued left knee pain and was noted to have had a prior left knee injection during October 2013. The objective findings on examination included antalgic gait; difficulty with heel toe walking on the left; positive sensory deficits on the left at L5-S1 dermatome; SLR (straight leg raise) positive on the left; left knee extension and hip extensors were all weak; decreased range of motion to the left knee; guarding crepitus and tenderness left knee. The patient reported no significant relief from the left knee injection performed on 3/25/2014. The patient was a candidate for left total knee replacement, but is deferring surgery. The patient received no significant benefit from the lumbar epidural steroid injection performed on 2/21/2014. The treatment plan included Synvisc injection to the left knee; x-rays of the left knee; MRI left knee; and a selective nerve root block at L4-L5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left knee injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hyaluronic acid injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 240, 337-339, Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter--Hyaluronic acid injections.

**Decision rationale:** The patient is diagnosed with advanced osteoarthritis of the left knee and is being recommended another Synvisc injection for continued knee pain directed to the diagnosis of unspecified osteoarthritis. The patient is noted to have been recommended to have a TKA, but has deferred surgery. The prior Synvisc injection provided no real relief to the knee and no functional improvement. Therefore, there is no medical necessity for the provision of another Synvisc injection to the left knee. The provider did not document objective evidence to support the medical necessity of continued viscosupplementation for the treatment of the left knee in relation to the criteria recommended by the California MTUS. The Official Disability Guidelines recommend viscosupplementation as indicated for patients who: Experience significantly symptomatic osteoarthritis but have not responded adequately to standard nonpharmacologic and pharmacologic treatments or are intolerant of these therapies (e.g., gastrointestinal problems related to anti-inflammatory medications). Are not candidates for total knee replacement or who have failed previous knee surgery for their arthritis, such as, arthroscopic debridement. Younger patients wanting to delay total knee replacement.

**Left knee MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, MRI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter--MRI.

**Decision rationale:** There was no rationale provided to support the medical necessity of the MRI of the left knee directed to the diagnosis of advanced OA of the left knee with recommended TKA. The objective findings on examination documented did not support the medical necessity of a repeated MRI of the knee. The patient was authorized x-rays to the knee which have not been obtained and interpreted. The medical necessity of a MRI for this patient was not supported with the objective findings documented on examination and there was no rationale to support medical necessity. The objective findings recommended by the CA MTUS; the ACOEM Guidelines 2nd edition and the Official Disability Guidelines for the authorization of an MRI of the knee were not documented in the available clinical documentation. The ACOEM Guidelines state that reliance on MRIs of the knee for a diagnosis can lead to diagnostic confusion. The Official Disability Guidelines (ODG) states that "that MRI is useful, but should be reserved for situations in which an experienced clinician requires further information before arriving at a diagnosis." There is no further diagnostic information available other than the x-ray

documentation of compartment collapse. The MRI is an adjunct to the objective findings on the physical examination.

**Lumbar spine MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines, MRI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter, MRI lumbar spine.

**Decision rationale:** The request for the authorization of an MRI of the lumbar spine for the diagnosis of lumbar spine pain was not supported with objective evidence on examination by the treating physician as there were no neurological deficits documented and no red flags documented for the reported pain to the back, which did not radiate to the lower extremities. The patient was ordered a MRI of the lumbar spine to rule out HNP (herniated nucleus pulposus) as a screening study. There was no evidence of changes in clinical status to warrant imaging studies of the lumbar spine. The request was not made with the contemplation of surgical intervention, but as a screening study. There was no rationale provided to support the medical necessity of the requested MRI of the lumbar spine. The patient was not noted to have objective findings documented consistent with a change in clinical status or neurological status to support the medical necessity of a MRI of the lumbar spine. The patient was documented to have subjective complaints of pain to the lower back with no documented radiation to the LEs (lower extremities). The patient reported persistent pain; however, there were no specified neurological deficits. There was no demonstrated medical necessity for a MRI of the lumbosacral spine based on the assessment. There are no documented progressive neurological changes as objective findings documented consistent with a lumbar radiculopathy as the effects of the DOI (date of injury). There was no documented completion of the ongoing conservative treatment to the lower back and there is no specifically documented HEP (home exercise program) for conditioning and strengthening. There are no demonstrated red flag diagnoses as recommended by the ODG or the ACOEM Guidelines. The use of the MRI for nonspecific back pain is only recommended after three months of symptoms with the demonstrated failure of conservative care. The request for a MRI of the lumbar spine is demonstrated to be not medically necessary.

**Left selective nerve root block L4-5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines, diagnostic epidural steroid injection.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 179-180, Chronic Pain Treatment Guidelines Epidural Steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section low back chapter lumbar spine ESI.

**Decision rationale:** The criteria required by the CA MTUS for the provision of a repeated transforaminal lumbar ESI or a selective nerve root block were not documented. The patient does not meet the CA MTUS criteria for a repeated lumbar ESI under fluoroscopic guidance as the patient has received two (2) or more lumbar ESIs. The last ESI provided no significant relief. The use of lumbar spine ESIs is recommended for the treatment of acute or subacute radicular pain in order to avoid surgical intervention. The reported radiculopathy was not corroborated by imaging studies or Electrodiagnostic studies. There is no impending surgical intervention. The patient is being treated for chronic low back pain. The stated diagnoses and clinical findings do not meet the criteria recommended by evidence based guidelines for the use of a lumbar ESI by pain management. The CA MTUS requires that "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing." The ACOEM Guidelines updated Back Chapter revised 8/08/08 does not recommend the use of lumbar ESIs for chronic lower back pain. The Official Disability Guidelines recommend that ESIs are utilized only in defined radiculopathies and a maximum of two lumbar diagnostic ESIs and a limited number of therapeutic lumbar ESIs are recommended in order for the patient to take advantage of the window of relief to establish an appropriate self-directed home exercise program for conditioning and strengthening. The patient has already received the number of recommended ESIs and has reported no functional improvement. The criteria for a second diagnostic ESI is that the claimant obtain at least 50% relief from the prior appropriately placed ESI. The therapeutic lumbar ESIs are only recommended "if the patient obtains 50-70% pain relief for at least 6-8 weeks." Additional blocks may be required; however the consensus recommendation is for no more than 4 blocks per region per year. The indications for repeat blocks include "acute exacerbations of pain or new onset of symptoms". Lumbar ESIs should be performed at no more than two levels at a session. Although epidural injection of steroids may afford short-term improvement in the pain and sensory deficits in patients with radiculopathy due to herniated nucleus pulposus, this treatment, per the guidelines, seems to offer no significant long-term functional benefit, and the number of injections should be limited to two, and only as an option for short term relief of radicular pain after failure of conservative treatment and as a means of avoiding surgery and facilitating return to activity. The patient is being treated for a subjective radiculitis with reported chronic low back without MRI or EMG/NCV evidence of a nerve impingement radiculopathy. There is no demonstrated medical necessity for a lumbar spine ESI for the reported chronic pain issues.