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| <b>Case Number:</b>   | CM15-0029545 |                              |            |
| <b>Date Assigned:</b> | 02/23/2015   | <b>Date of Injury:</b>       | 04/01/2013 |
| <b>Decision Date:</b> | 04/06/2015   | <b>UR Denial Date:</b>       | 02/07/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/17/2015 |

### 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: 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:

The injured worker is a 65 year old male, who sustained an industrial injury on April 1, 2013. He has reported low back pain with radiating pain and tingling in the lower extremities, sharp left hip pain and left knee pain. The diagnoses have included lumbar spine herniated nucleus pulposus, lumbar radiculopathy, low back pain, left hip internal derangement, status post fracture of the head and neck of the femur requiring surgical correction, pain in the left thigh, status post fracture of the lower end of the femur, left knee sprain, left medial meniscus tear and chondromalacia patella of the left knee. Treatment to date has included radiographic imaging, diagnostic studies, multiple surgical interventions of the left lower extremity, conservative therapies, pain medications and work restrictions. Currently, the IW complains of low back pain with radiating pain and tingling in the lower extremities, sharp left hip pain and left knee pain. The injured worker reported an industrial injury in 2013, resulting in the above described pain. He required surgical and conservative interventions however the pain is persistent. Evaluation on August 29, 2014, revealed continued pain, shockwave therapy was requested and intense localized neurostimulation therapy. Examination on February 24, 2015, revealed continued pain. It was noted previous trigger point injection provided some relief. On February 7, 2015, Utilization Review non-certified a request for 1 series of 3 PRP injections for the left knee and 18 sessions of acupuncture for the left hip and left knee, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On February 12, 2015, the injured worker submitted an application for IMR for review of requested 1 series of 3 PRP injections for the left knee and 18 sessions of acupuncture for the left hip and left knee.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Series of three platelet-rich plasma (PRP) injections to 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 & 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) Chapter: Knee  
Source: Platelet-Rich Plasma.

**Decision rationale:** The Official Disability Guidelines comment on the use of Platelet-Rich Plasma (PRP) as a treatment modality for problems of the knee. These guidelines state that PRP is currently under study. A small study found a statistically significant improvement in all scores at the end of multiple platelet-rich plasma (PRP) injections in patients with chronic refractory patellar tendinopathy and a further improvement was noted at six months, after physical therapy was added. The clinical results were encouraging, indicating that PRP injections have the potential to promote the achievement of a satisfactory clinical outcome, even in difficult cases with chronic refractory tendinopathy after previous classical treatments have failed. Platelets are known to release various growth factors that are associated with tissue regeneration/healing and angiogenesis, as well as a variety of chemicals (adenosine, serotonin, histamine, and calcium) that may be important in inhibiting inflammation and promoting angiogenesis. The exact mechanism of action in the context of PRP is still being investigated. The healing process in both muscle and tendon injuries starts with an inflammatory/destruction phase, followed by a repair/proliferation phase and then by a remodeling phase. This process is affected by various factors, such as growth factors, immune cells, and numerous chemomodulators, many of which are found in PRP. Findings of in vitro studies and animal studies have suggested that PRP can potentially decrease the inflammatory response and promote the repair and remodeling phases of healing in both muscle and tendon. PRP represents a novel noninvasive treatment method for patients with acute or chronic soft-tissue musculoskeletal injuries. The popularity of PRP has increased in the medical community, and it has received increased media attention in recent years, particularly because professional athletes have undergone this procedure. There is a need for further basic-science investigation, as well as randomized, controlled trials to identify the benefits, side effects, and adverse effects that may be associated with the use of PRP for muscular and tendinous injuries. Further clarification of indications and time frame is also needed. PRP looks promising, but it is not yet ready for prime time. PRP has become popular among professional athletes because it promises to enhance performance, but there is no science behind it yet. A study of PRP injections in patients with early arthritis compared the effectiveness of PRP with that of low-molecular-weight hyaluronic acid and high-molecular-weight hyaluronic acid injections, and concluded that PRP is promising for less severe, very early arthritis, in younger people under 50 years of age, but it is not promising for very severe osteoarthritis in older patients. PRP appears to improve the healing of patellar tendon graft sites after anterior cruciate ligament (ACL) reconstruction, but the intervention didn't have any

clinical impact. The authors concluded that PRP is a promising therapy for sports injuries, but more studies are needed to clarify the specific indications. Platelet-rich plasma injections can benefit patients with cartilage degeneration and early osteoarthritis (OA) of the knee, according to this RCT. In patients with minimal OA, platelet-rich plasma (PRP) works better than hyaluronic acid. The evidence shows that young patients in the PRP group continued to improve a little between follow-ups and that the patients receiving hyaluronic acid get a little worse. So far, however, no medical studies support using PRP for prevention in sports medicine. After 2 decades of clinical use, results of PRP therapy are promising but still inconsistent. This pilot study suggests that platelet-rich plasma may play a role in improving clinical outcomes in patients with early onset osteoarthritis at both 6 months and 1 year, and PRP seemed to result in no change by MRI per knee compartment in at least 73% of cases at 1 year, in contrast to an expectation that OA would worsen. In this case the patient has multiple diagnoses listed that contribute to his ongoing knee problems. There is insufficient evidence based on the findings of the above cited guidelines that support the efficacy of PRP. Therefore, a series of three PRP injections to the left knee is not considered as medically necessary.

**Eighteen sessions of acupuncture for the left hip and knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Page(s): 13.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of acupuncture as a treatment modality and refer to Section 9792.24.1 of the California Code of Regulations, Title 8, under the Special Topics section. This section addresses the use of acupuncture for chronic pain in the workers' compensation system in California. These guidelines state the following: That acupuncture is used as an option when pain medication is reduced or not tolerated. Further, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. These guidelines also comment on the frequency and duration of acupuncture treatments. Specifically, that: The time to produce functional improvement is 3-6 treatments. The frequency of acupuncture treatments should be 1-3 times per week. The optimal duration of acupuncture is 1-2 months. Based on the information in the medical records, there is no evidence that the requested service is being used as an adjunct to physical rehabilitation or surgical intervention. There is also no evidence in the medical records to indicate that the pain medications prescribed are being reduced or not tolerated. Finally, the request was for 18 sessions of acupuncture treatment for the left hip and knee. Eighteen sessions as proposed is not consistent with the above cited guidelines. In the Utilization Review Process the request was modified to six sessions which is consistent with these guidelines. In summary, 18 sessions of acupuncture for the left hip and knee is not considered as medically necessary.

**Eighteen sessions of acupuncture for the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Page(s): 13.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of acupuncture as a treatment modality and refer to Section 9792.24.1 of the California Code of Regulations, Title 8, under the Special Topics section. This section addresses the use of acupuncture for chronic pain in the workers' compensation system in California. These guidelines state the following: That acupuncture is used as an option when pain medication is reduced or not tolerated. Further, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. These guidelines also comment on the frequency and duration of acupuncture treatments. Specifically, that: The time to produce functional improvement is 3-6 treatments. The frequency of acupuncture treatments should be 1-3 times per week. The optimal duration of acupuncture is 1-2 months. Based on the information in the medical records, there is no evidence that the requested service is being used as an adjunct to physical rehabilitation or surgical intervention. There is also no evidence in the medical records to indicate that the pain medications prescribed are being reduced or not tolerated. Finally, the request was for 18 sessions of acupuncture treatment for the lumbar spine. Eighteen sessions as proposed is not consistent with the above cited guidelines. In the Utilization Review Process the request was modified to six sessions which is consistent with these guidelines. In summary, 18 sessions of acupuncture for the lumbar spine is not considered as medically necessary.

**One referral to an orthopedic surgeon for consultation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343 - 344.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 75-92.

**Decision rationale:** The MTUS/ACOEM Guidelines comment on the clinician's role in the ongoing management of a patient's condition. As part of this role, the clinician should assess for the presence of "red flag" symptoms which may be indicators of a serious underlying condition and impact management decisions including referral. Further, the clinician may determine at a point in the ongoing assessment of a patient's condition that referral is warranted. In this case, it is unclear what is the specific question being asked by the Orthopedic Surgeon in the referral process. There is no evidence that the patient is being considered a surgical candidate. Further, it is unclear which of the patient's orthopedic issues are in need of a consultant's opinion. Without further clarity as to the rationale for a specialty referral, an orthopedic consultation is not considered as medically necessary.

**One referral to pain management specialist regarding lumbar ESI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 345, table 13-6.

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

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Epidural Steroid Injections (ESIs) as a treatment modality. These guidelines recommend ESIs as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The MTUS guidelines also comment on the criteria for the use of ESIs. These criteria are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, it is unclear that the patient meets the above cited criteria #2. Specifically, that the patient has been unresponsive to conservative treatments. As noted in this case, the patient has been approved for 6 sessions of acupuncture and it has not yet been established whether this conservative treatment modality has been unsuccessful. For this reason, referral to a pain management specialist for a lumbar ESI is not considered as medically necessary.6. EMG/NCV study of the bilateral lower extremities is not medically necessary and appropriate. The Claims Administrator based its decision on the MTUS ACOEM Practice Guidelines, Chapter 12 Low Back Complaints, page 303 and on the Non-MTUS Official Disability Guidelines (ODG), Low Back Chapter.

**EMG/NCV study of the bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back & Thoracic/Acute & Chronic Section: Electrodiagnostic Studies.

**Decision rationale:** The Official Disability Guidelines comment on the use of electrodiagnostic studies to include EMGs and NCVs. These guidelines state that Nerve Conduction Studies are not recommended for low back conditions; however, EMGs (Electromyography) which are recommended as an option for low back. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. The guidelines provide the following minimum standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic

Medicine (AANEM) recommends the following minimum standards: (1) EDX testing should be medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, peripheral neuropathy). (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for screening purposes rather than diagnosis are not acceptable. (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis. (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. If both tests are done, the reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. (7) If both tests are done, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009) Note: For low back NCS are not recommended and EMGs are recommended in some cases, so generally they would not both be covered in a report for a low back condition. In this case, the request is for EMG and NCV of the bilateral lower extremities. Per the above cited guidelines the combination of studies is not recommended. Further, the medical records indicate that the patient has undergone EMG studies in July, 2014. The records do not indicate that there has been a significant change in symptoms or physical examination findings since the date of the prior study. For these reasons EMG/NCV of the bilateral lower extremities is not considered as medically necessary.