

<b>Case Number:</b>	CM15-0110548		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	04/08/2014
<b>Decision Date:</b>	09/15/2015	<b>UR Denial Date:</b>	05/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/08/2015

### 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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 66 year old male, who sustained an industrial injury on April 8, 2014. He reported a back injury. The injured worker was diagnosed as having spinal contusion, spinal discopathy with left-sided radiculopathy, left knee internal derangement with arthrosis, lumbar 4-lumbar 5 and lumbar 5-sacral 1 discopathy with lumbar radiculopathy, and significant lumbago with multilevel discopathy. Diagnostic studies to date have included: On April 25, 2014, an MRI of the lumbar spine revealed spondylotic changes with endplate sclerotic changes within the inferior endplate of lumbar 5 and superior endplate of sacral 1. There was disc desiccation from lumbar 3 through sacral 1. At lumbar 3-4, there was a posterior annular tear with intervertebral disc, a 1 to 2 millimeter posterior disc bulge effacing the ventral surface of the thecal sac resulting in moderate bilateral neural foraminal narrowing and bilateral exiting nerve root compromise. At lumbar 4- 5, there was a 2-3 millimeter posterior disc bulge effacing the ventral surface of the thecal sac resulting in moderate to severe bilateral neural foraminal narrowing. There was mild canal stenosis and bilateral exiting nerve root compromise. At lumbar 5-sacral 1, there was a 3-4 millimeter posterior disc bulge effacing the ventral surface of the thecal sac resulting in moderate to severe bilateral neural foraminal narrowing, and bilateral exiting nerve root compromise. There was mild canal stenosis and bilateral exiting nerve root compromise. On July 11, 2014, electrodiagnostic studies revealed an incidental finding of deep accessory peroneal nerve on the left side and decreased amplitude of compound motor action potential on the bilateral extensor digitorum brevis muscle secondary to atrophy of these muscles. On November 17, 2014, the treating physician noted the results of x-rays of the lumbar spine and left knee from an unspecified date. The lumbar spine revealed moderately severe disc space

narrowing at the lumbar 5-sacral 1 disc space and a slight decreased disc space at lumbar 4-lumbar 5 with moderate hypertrophic spur formation and foraminal narrowing. The left knee x-rays revealed a moderate amount of decreased medial joint space, minimal hypertrophic spur formation of the patello-femoral joint, and slight hypertrophic spur formation of the femoral tibial articulation. Treatment to date has included acupuncture, physical therapy, aquatic therapy, home exercise, lumbar epidural steroid injection, a lumbar corset, and medications including topical analgesic, oral analgesic, and muscle relaxant. There were no noted previous injuries or dates of injury, and no noted comorbidities. On April 10, 2015, the injured worker complained of ongoing burning pain of the low back and left knee. His pain is rated 7/10. He reported crunching, grinding, and a significant amount of swelling when going up and down stairs over a few days prior to this visit. He noted some laxity of the knee and he was limping. He also complained of increased spinal pain. The physical exam revealed inability to stand erect, a slightly antalgic gait, tender buttocks, and inability to fully squat due to pain. There was tenderness of the thoracolumbar spine down to the base of the pelvis, some tenderness on stress of the pelvis indicating mild sacroiliac joint symptomology, and decreased lumbar spine range of motion. There were intact deep tendon reflexes of the knees and ankles, no gross motor weakness in the lower extremities, mild pain caused by motor strength testing, intact sensation to pinprick of the lower extremities, and mild sciatic stretch bilaterally. There was abnormal patellar tacking of the left knee with a positive patellar grind maneuver, hamstring tenderness, tenderness over the medial and lateral aspects, mild swelling, and effusion. There was a positive McMurray's test, negative Drawer test and Lachman Instability, a mildly positive varus-valgus stress test, and a negative instability test. There was normal range of motion and strength of the left knee. The injured worker underwent a Celestone and Lidocaine injection of the left knee. His work status remains temporarily totally disabled. Requested treatments include: a corticosteroid injection to the left knee consisting of Celestone and Lidocaine, a TENS unit, Gabapentin 10 Percent, Ketoprofen 10 Percent, Cyclobenzaprine 4 Percent, Menthol 2 Percent, Camphor 2 Percent/Capsaicin .0375 Percent 180 Grams, and x-rays of the lumbar spine and left knee.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Corticosteroid Injection to The Left Knee Consisting of Celestone and Lidocaine:**

Overtaken

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339; 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic): Corticosteroid injections.

**Decision rationale:** According to the ACOEM (American College of Occupational and Environmental Medicine) guidelines, corticosteroid injections are recommended as an option, but they are not routinely indicated. The Official Disability Guidelines (ODG) recommends intra-articular corticosteroid injections of the knee for short-term use only and the number of injections should be limited to three. The criteria for Intraarticular

glucocorticosteroid injection include: "Documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria, which requires knee pain and at least 5 of the following: (1) Bony enlargement; (2) Bony tenderness; (3) Crepitus (noisy, grating sound) on active motion; (4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr.; (5) Less than 30 minutes of morning stiffness; (6) No palpable warmth of synovium; (7) Over 50 years of age; (8) Rheumatoid factor less than 1:40 titer (agglutination method); and (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm<sup>3</sup>)." The aspiration of knee effusions prior to injection is preferred, but not required. In addition, knee pain that is inadequately controlled by recommended conservative treatments (exercise, NSAIDs or acetaminophen) with impaired functional activities (e.g., ambulation, prolonged standing) are required. Glucocorticosteroid injections are intended for short-term control of symptoms to resume conservative medical management or delay total knee arthroplasty. A review of the injured workers medical records reveal that he meets some of the criteria described above, including but not limited to being over 50, has crepitus and is not responding adequately to conservative management with impaired function, the use of a corticosteroid injection appears appropriate in this injured worker, therefore the request for Corticosteroid Injection to The Left Knee Consisting of Celestone and Lidocaine is medically necessary.

**TENS Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy: TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114.

**Decision rationale:** Per the California Medical Treatment Utilization Schedule (MTUS) guidelines, transcutaneous electrical nerve stimulation (TENS) is recommended when there is evidence of pain of at least three months duration, trial and failure of other appropriate pain modalities (including medication), and a one-month trial period of the TENS unit as an adjunct to ongoing treatment modalities within a functional restoration approach that includes documentation of how often the unit was used, and pain relief and function outcomes; rental would be preferred over purchase during this trial. In addition, documentation should include evidence of medication usage, a treatment plan with the specific short- and long-term goals of treatment with the TENS unit, and a two lead is generally recommended. Per the CMTUS guidelines, TENS is recommended for the treatment of chronic intractable pain for the following conditions diabetic neuropathy and post-herpetic neuralgia, phantom limb pain, complex regional pain syndrome I and II, spasticity in spinal cord injury, and multiple sclerosis pain and muscle spasm. There is lack of evidence that the injured worker is diagnosed with any of the conditions approved for TENS treatment. There was evidence of prior conservative measures having provided some relief. There is lack of evidence of a one-month trial period of the TENS unit as an adjunct to ongoing treatment modalities within a functional restoration approach that includes documentation of how often the unit was used, and pain relief and function outcomes. Therefore, the request for a TENS unit is not medically necessary.

**Gabapentin 10 Percent/Ketoprofen 10 Percent/Cyclobenzaprine 4 Percent/Menthol 2 Percent/Camphor 2 Percent/Capsaicin .0375 Percent 180 Grams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. A review of the injured workers medical records that are available to me does not show a trial of recommended first line agents that have failed and gabapentin and ketoprofen are not recommended by the guidelines for topical use, therefore the request for Gabapentin 10 Percent/Ketoprofen 10 Percent/Cyclobenzaprine 4 Percent/Menthol 2 Percent/Camphor 2 Percent/Capsaicin .0375 Percent 180 Grams is not medically necessary.

**X-Ray of The Lumbar Spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287; 303.

**Decision rationale:** Per the ACOEM (American College of Occupational and Environmental Medicine) guidelines, X-rays of the lumbar spine are recommended when there are red flags for serious spinal pathology present and the injured worker's back pain has persisted beyond six weeks and for cases in which surgery is being considered. There was lack of evidence of red flags for serious spinal pathology. There was no documentation of surgery being considered for the injured worker. Therefore the request for x-ray of the lumbar spine is not medically necessary.

**Knee Sleeve:** 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340; 346.

**Decision rationale:** Per the ACEOM guidelines, a knee brace is recommended when there is patellar instability, anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL)

instability and the knee will be stressed under load, such as climbing ladders or carrying boxes. In addition ACOEM recommends that the use of braces must be combined with a rehabilitation program. There was lack of evidence of patellar instability, anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL) instability and that the injured worker would be stressing his left knee under load. There was no documentation of the adjunctive use of a rehabilitation program. the injured worker does not appear to meet the criteria for a knee sleeve as recommended by the guidelines, therefore the request for knee sleeve is not medically necessary.