MAXIMUS Federal Services

| Case Number: | CM15-0126023 | | |
|---|---|---|---|
| Date Assigned: | 07/10/2015 | Date of Injury: | 10/05/2009 |
| Decision Date: | 09/16/2015 | UR Denial Date: | 06/09/2015 |
| Priority: | Standard | Application Received: | 06/30/2015 |

## 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: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 51 year old male who sustained an industrial injury on 10/5/09. Diagnoses are thoracic involvement with facet inflammation, discogenic lumbar condition with facet inflammation radiculopathy especially on the left- MRI shows disc bulging and wear at L4-L5 and L5-S1, status post epidural injection and facet injection, discogenic cervical condition with live-level disc disease - status post epidural injection and facet injection, impingement syndrome right shoulder-status post 1 injection, impingement syndrome left shoulder with decompression and subscapularis repair-status post 4 injections, status post 1 injection along the biceps tendon with relief-12/2014, internal derangement of knees bilaterally with MRI showing partial anterior cruciate ligament tear on the right and wear on the knee meniscus bilaterally-status post 1 injection to each knee, carpal tunnel syndrome on the right, cubital tunnel syndrome on the left, and due to chronic pain-has issues with sleep; stress disorder; and depression. Objective exam notes neck flexion is 30 degrees and extension is 20. Abduction is 140 degrees on the right and 95 on the left, with discomfort. There is tenderness along the biceps tendon on the left side, lumbar flexion is 55 degrees and extension is 20 degrees. At the knees, he has 175 degrees of extension and 110 degrees of flexion on the left and 120 degrees on the right. Work status is noted as he has limitation with reaching; forceful activities; prolonged standing, walking, squatting, kneeling, stairs, prolonged sitting/standing and forceful pushing/pulling. An MRI of the left knee done 12/29/14 shows minor myxoid degenerative changes centrally within the posterior horn and body of the medial meniscus, otherwise no significant findings for internal derangement, Previous treatment includes a lumbar brace, neck traction, hinged knee brace-bilateral, hinged elbow brace, a cane, hot and cold wrap, transcutaneous electrical nerve

stimulation unit-which has been beneficial, and Morphine. Medications prescribed are Morphine, Nalfon, Protonix, Flexeril, Neurontin, and Tramadol ER. The requested treatment is injections to the iliac crest-left side, injection at the left knee, MRI of the mid-back, Nerve studies-left lower extremity, and Nerve studies-right lower extremity.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Injections to iliac crest, left side:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections), Epidural steroid injections (ESIs), therapeutic and Other Medical Treatment Guidelines MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

**Decision rationale:** ACOEM Guidelines report that Invasive techniques (e.g., local injections and facet-joint injections of cortisone and Lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. ODG and MD Guidelines agree that: One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. Physical exam findings do not suggest that extension and rotation significantly exacerbate low back pain. Additionally, the treating physician does not document lumbar rigidity, level of pain relief as it pertains to conservative treatments, or specify what the multiple positive exam findings were. As such, the request for Injections to iliac crest, left side is not medically necessary.

**Injection at left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 345-347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Corticosteroid injections.

**Decision rationale:** ACOEM states that for aspirations and injections of the knee that “Panel interpretation of information not meeting inclusion criteria for research-based evidence.” It is a D recommendation. ODG states Recommended for short-term use only. The ODG criteria are listed below. Criteria for Intraarticular glucocorticosteroid injections: 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); (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm3); Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen); Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; Intended for short-term control of symptoms to resume conservative medical management or delay TKA; Generally performed without fluoroscopic or ultrasound guidance; Absence of synovitis, presence of effusion preferred (not required); Aspiration of effusions preferred (not required); Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three. The treating physician has not provided documentation to meet at least 5 of the above criteria to justify a knee injection at this time. As such, Injection at left knee is not medically necessary.

**MRI mid-back:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging.

**Decision rationale:** MTUS and ACOEM recommend MRI, in general, for low back pain when cuada equine, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative, MRI test of choice for patients with prior back surgery. ACOEM additionally recommends against MRI for low back pain before 1 month in absence of red flags. ODG states, Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. ODG lists criteria for low back and thoracic MRI, indications for imaging; Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit; Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit); Uncomplicated low back pain, suspicion of cancer, infection, other red flags; Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit; Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome; Myelopathy (neurological deficit related to the spinal cord), traumatic; Myelopathy, painful; Myelopathy, sudden onset; Myelopathy, stepwise progressive; Myelopathy, slowly progressive; Myelopathy, infectious disease patient; Myelopathy, oncology patient; While the patient does have pain lasting greater than one month, there is no documented conservative therapy or progressive neurological deficit. The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. As such, the request for MRI mid-back is not medically necessary.

**Nerve studies, left lower extremity:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), EMG, NCV.

**Decision rationale:** ACOEM recommends Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. ODG further states that EMG is recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. ODG does not recommend NCV testing by stating NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. The medical documentation provided does not indicate any subjective complaints or objective findings that would warrant the requested testing. As such, the request for Nerve studies, left lower extremity is not medically necessary.

**Nerve studies, right lower extremity:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), EMG, NCV.

**Decision rationale:** ACOEM recommends Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. ODG further states that EMG is recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. ODG does not recommend NCV testing by stating NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. The medical documentation provided does not indicate any subjective complaints or objective findings that would warrant the requested testing. As such, the request for Nerve studies, right lower extremity is not medically necessary.