

<b>Case Number:</b>	CM15-0169919		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	04/19/2014
<b>Decision Date:</b>	11/02/2015	<b>UR Denial Date:</b>	07/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2015

### 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: Emergency 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:

This 66 year old female sustained an industrial injury to the left knee and low back on 4-19-14. Previous treatment included physical therapy (six sessions) and medications. Magnetic resonance imaging lumbar spine (6-17-14) showed anterolisthesis at L4-5 and L5-S1 with stenosis. X-rays of the left knee (8-7-14) showed severe degenerative changes with medial joint space loss, osteophytes and patella femoral disease. In a worker's compensation re-evaluation dated 7-21-15, the injured worker complained of ongoing low back pain rated 5 out of 10 on the visual analog scale and left knee pain, rated 7 out of 10, associated with swelling, popping and weakness. The injured worker reported that her left knee pain had worsened since her last office visit and that she had lost her balance on several occasions due to left knee weakness. Physical exam was remarkable for lumbar spine with normal alignment, mild tenderness to palpation to the bilateral paraspinal process, 70 degrees flexion, 20 degrees extension, 5 out of 5 lower extremity motor strength and decreased sensation in the S1 and L5 distribution and left knee with mild effusion, positive crepitus on range of motion, medial and lateral joint line tenderness to palpation without instability, negative posterior drawer test and pain upon varus and valgus stress test. Current diagnoses included lumbar spine stenosis, lumbago and lumbar spine radiculitis. The physician noted that the injured worker had been doing physical therapy at home which had helped her back pain but not her radicular pain. The treatment plan included requesting authorization for left L5-S1 selective nerve root block, left knee Supartz injections once a week for three weeks, physical therapy twice a week for six weeks and medications (Anaprox, Norco and Nexium). On 7-31-15, Utilization Review noncertified a request for selective nerve root block at left L6 and S1 noting no documentation of a magnetic resonance imaging report. Utilization Review non-certified a request for Supartz injections for the left knee noting lack of documentation of

significantly symptomatic osteoarthritis that did not respond to standard treatment. Utilization Review noncertified a request for physical therapy twice a week for six weeks noting lack of documentation of objective improvement with previous treatment. Utilization Review noncertified a request for Norco noting lack of documentation of pain relief, functional status, appropriate medications use and side effects to support the medical necessity of opioids.

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

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

**Selective nerve root block at left L6 and S1 with fluoroscopy guidance and sedation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back/Epidural steroid injections, diagnostic.

**Decision rationale:** The request is for a selective nerve root block. The official disability guidelines state the following regarding qualifying criteria for this procedure: Recommended in selected cases as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed, in part, as a diagnostic technique to determine the level of radicular pain. The role of these blocks has narrowed with the advent of MRIs. Few studies are available to evaluate diagnostic accuracy or post-surgery outcome based on the procedure and there is no gold standard for diagnosis. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004) (Benzon, 2005) When used as a diagnostic technique a small volume of local is used (<1.0 ml) as greater volumes of injectate may spread to adjacent levels. (Sasso, 2005) (Datta, 2013) (Beynon, 2013) Indications for diagnostic epidural steroid injections: 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below: 2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies; 3) To help to determine pain generators when there is evidence of multi-level nerve root compression; 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive; 5) To help to identify the origin of pain in patients who have had previous spinal surgery. In this case, this procedure is not indicated. This is secondary to poor documentation of diagnostic imaging which is ambiguous in regard to the level of radicular pain as stated above.

As such, the request is not certified pending receipt of this information and therefore is not medically necessary.

**Supartz injections once a week for three weeks for the left knee quantity: 3:** 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), Hyaluronic acid injections.

**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 (Hyaluronic acid injections).

**Decision rationale:** Qualifying criteria as listed below: Criteria for Hyaluronic acid injections: Patients experience significantly symptomatic osteoarthritis but have not responded adequately to recommended conservative non-pharmacologic (e.g., exercise) and pharmacologic treatments or are intolerant of these therapies (e.g., gastrointestinal problems related to anti-inflammatory medications), after at least 3 months; Documented symptomatic severe osteoarthritis of the knee, which may include the following: Bony enlargement; Bony tenderness; Crepitus (noisy, grating sound) on active motion; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Over 50 years of age; Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; Failure to adequately respond to aspiration and injection of intra-articular steroids; Generally performed without fluoroscopic or ultrasound guidance; Are not currently candidates for total knee replacement or who have failed previous knee surgery for their arthritis, unless younger patients wanting to delay total knee replacement. (Wen, 2000) Repeat series of injections: If documented significant improvement in symptoms for 6 months or more, and symptoms recur, may be reasonable to do another series. No maximum established by high quality scientific evidence; see Repeat series of injections above; Hyaluronic acid injections are not recommended for any other indications such as chondromalacia patellae, facet joint arthropathy, osteochondritis dissecans, or patellofemoral arthritis, patellofemoral syndrome (patellar knee pain), plantar nerve entrapment syndrome, or for use in joints other than the knee (e.g., ankle, carpo-metacarpal joint, elbow, hip, metatarsophalangeal joint, shoulder, and temporomandibular joint) because the effectiveness of hyaluronic acid injections for these indications has not been established. In this case, the use of this treatment is not indicated. This is secondary to inadequate documentation of failure to adequately respond to aspiration and injection of intra-articular steroids. As such, the request is not certified and therefore is not medically necessary.

**Physical therapy two times a week for six weeks for the lumbar spine quantity: 12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. The number of treatments request is beyond what the guideline advises. As such, the request is not certified and therefore is not medically necessary.

**Norco 5/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement, which should eventually lead to medication discontinuation. As such, the request is not certified. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome and therefore is not medically necessary.