

<b>Case Number:</b>	CM15-0179984		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	04/19/2004
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### 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 34 year old female who sustained an industrial injury on 4-19-2004. A review of medical records indicates the injured worker is being treated for constipation, gastroesophageal reflux disease, gastritis, post traumatic weight gain, and sleep disorder, secondary to pain, rule out obstructive sleep apnea. Medical records dated 6-18-2015 noted symptoms are well controlled with medications. She reported acid reflux, which is well controlled with medication. She denies any chest pain, shortness of breath, or palpitations. Physical examination noted lungs were clear with a regular heart rate and rhythm. Abdomen was soft with normoactive bowel sounds. Treatment has included medications. A report dated August 13, 2015 is incomplete but notes sensory loss in the S1 dermatome of the left lower extremity and motor deficit in the S-1 distribution on the left. Additional portions of that note indicate that the patient has undergone a previous MRI of the lumbar spine and at least 2 MRIs of the left knee. Notes indicate that she has undergone chiropractic care previously. Utilization review form dated 9-8-2015 noncertified autonomic nervous parasympathetic inervj to the lumbar spine, MRI of the left knee, acupuncture 2x6 left knee, updated MRI of the lumbar spine, and physical therapy 2x6 lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Autonomic nervous parasympathetic innervj to lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, CRPS, sympathetic blocks (therapeutic).

**Decision rationale:** Regarding the request for "Autonomic nervous parasympathetic innervj to lumbar spine", it is unclear what is being requested here whether it is a request for an autonomic block (sympathetic or parasympathetic), or autonomic testing of some sort. Chronic Pain Medical Treatment Guidelines state that there is limited evidence to support the use of regional sympathetic blocks. ODG states that they are indicated for the treatment of CRPS once other diagnoses have been ruled out. Within the documentation available for review, it is unclear what exactly is being requested, and what it would be intended to treat or diagnose. There is no indication that the patient has a diagnosis of CRPS or any other dysfunction of the autonomic nervous system. As such, the currently requested "Autonomic nervous parasympathetic innervj to lumbar spine" is not medically necessary.

**MRI left knee:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, MRI.

**Decision rationale:** Regarding the request for repeat MRI of the left knee, CA MTUS and ACOEM note that, in absence of red flags (such as fracture/dislocation, infection, or neurologic/vascular compromise), diagnostic testing is not generally helpful in the first 4-6 weeks. After 4-6 weeks, if there is the presence of locking, catching, or objective evidence of ligament injury on physical exam, MRI is recommended. ODG recommends plain radiographs in the absence of signs/symptoms of internal derangement or red flags. Within the medical information made available for review, there is no identification of any red flags or documentation that conservative treatment aimed towards the knee has failed. Furthermore, it appears the patient has undergone at least 2 previous MRIs of the knee, and there is no statement indicating how the patient's symptoms and findings have changed since the time of those most recent imaging studies. Finally, there is no indication as to how the medical decision-making will be changed based upon the outcome of this requested study. In the absence of such documentation, the currently requested repeat MRI of the left knee is not medically necessary.

**Acupuncture to left knee twice a week for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Acupuncture.

**Decision rationale:** Regarding the request for acupuncture to left knee twice a week for six weeks, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it is unclear what current concurrent rehabilitative exercises will be used alongside the requested acupuncture. Additionally, the current request for 12 visits exceeds the 6-visit trial recommended by guidelines. Unfortunately, there is no provision to modify the current request. Although not documented, if the patient has undergone acupuncture previously, there is no documentation of objective functional improvement as a result of those previous acupuncture sessions. As such, the currently requested acupuncture to left knee twice a week for six weeks is not medically necessary.

**Updated MRI of lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, MRIs (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** Regarding the request for repeat lumbar MRI, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG states that MRIs are recommended for uncomplicated low back pain with radiculopathy after at least one month of conservative therapy. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Within the documentation available for review, there is no statement indicating what medical decision-making will be based upon the outcome of the currently requested MRI. Furthermore, there is no documentation indicating how the patient's subjective complaints and objective findings have changed since the time of the most recent MRI of the lumbar spine. In the absence of clarity regarding those issues, the currently requested lumbar MRI is not medically necessary.

**Physical therapy to the lumbar spine twice a week for 6 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** Regarding the request for Physical therapy to the lumbar spine twice a week for 6 weeks, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, it is unclear if the patient has undergone previous physical therapy sessions. If so, there is no documentation of objective functional improvement as a result of those sessions as well as remaining objective treatment goals to be addressed with further therapy that could not be improved with an independent program of home exercise. If the patient has not undergone therapy previously, the currently requested 12 visits exceeds the number recommended as a trial by guidelines. As such, the current request for physical therapy to the lumbar spine twice a week for 6 weeks is not medically necessary.