

Case Number:	CM13-0042227		
Date Assigned:	12/27/2013	Date of Injury:	10/16/2012
Decision Date:	05/28/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/28/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 59-year-old with an injury reported on October 16, 2012 and the mechanism of injury occurred while working as a surgery support technician. The clinical note from May 18, 2013 indicated that the injured worker had severe low back pain and the pain was noted as 8/10. She described the pain to be aching, burning and mostly axial in nature. The physician indicated that at her last appointment a lumbar medial branch block was recommended on the right side but the authorization had not been received. The injured worker's medications included Norco, Soma, and Orphenadrine. On physical examination of the lumbar spine, the injured worker had moderate tenderness and spasms of the bilateral paraspinal muscles. The straight leg raise test was negative for radicular pain but did cause back pain. The lumbar facet loading was positive bilaterally and more pain was noted on the right. The lumbar range of motion was diminished in all planes but the extension caused significantly more pain than flexion. The physician indicated he reviewed [REDACTED] electromyography from March 22, 2013 and a lumbar MRI but the records were not provided for review. The treatment plan included continue home exercise program, conservative care, and a request will be sent again for a right lumbar medial branch nerve block/facet joint injection at the right L3, the right L4 and the right L5 levels for diagnostic and therapeutic purposes. The physician indicated that the injured worker does not have radicular components at this time. The physician's rationale for the current request was not provided. The current request is for bilateral sacroiliac joint injections, electromyography of lower extremities, and nerve conduction study of the lower extremities; however, the date of the request was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL SACROILIAC(SI) JOINT INJECTIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Injections Section..

Decision rationale: The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines (ODG) sacroiliac joint blocks are recommended as an option if there has been failure of at least 4-6 weeks of aggressive conservative therapy. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint. The documentation provided failed to indicate if the injured worker had failed at least 4-6 weeks of aggressive conservative therapy with medications and physical exercise. Also, the physical examination of the patient did not reveal the presence of physical examination findings consistent with sacroiliac joint dysfunction. The request for bilateral sacroiliac joint injections is not medically necessary or appropriate.

ELECTROMYOGRAPHY (EMG) OF LOWER EXTREMITIES: 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): 303-305.

Decision rationale: The Low Back Complaints Chapter of the ACOEM Practice Guidelines indicate that 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. The documentation provided noted the injured worker did not have radiular components or neurological deficits on examination to support the necessity of electrodiagnostic studies. Also, there was a lack of information provided regarding prior conservative care. The request for an EMG of the lower extremities is not medically necessary or appropriate.

NERVE CONDUCTION STUDY(NCS) OF THE LOWER EXTREMITIES: Upheld

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

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, Nerve conduction studies (NCS).

Decision rationale: The California MTUS/ACOEM Guidelines do not address the request. The Official Disability Guidelines for Nerve conduction studies (NCS) indicate they are not recommended and there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The documentation provided failed to provide evidence of neurological deficits on examination to support the necessity of electrodiagnostic studies. There was also a lack of information regarding conservative care. The request for an NCS of the lower extremities is not medically necessary or appropriate.