

Case Number:	CM14-0002345		
Date Assigned:	01/24/2014	Date of Injury:	08/21/2012
Decision Date:	06/10/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/07/2014

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 Emergency Medicine and is licensed to practice in New York. 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 patient is a 55-year-old female who was injured on August 21, 2012. The patient continued to experience left sacroiliac pain and left shoulder pain. Physical examination was notable for tenderness to the left sacroiliac joint, positive left straight leg raise, hyperesthesia of the left ulnar distribution, and tenderness over the left cubital tunnel. Diagnoses included left sacroilitis, left shoulder impingement syndrome, and upper extremity compression neuropathy/rule out cubital tunnel syndrome. Prior treatment included activity modification, physical therapy, home exercise and medication. The pain in the sacroiliac joint was refractory to these interventions. Requests for authorization for MRI of the left shoulder, electromyogram of the left upper extremity, nerve conduction velocity of the left upper extremity, and second left S1 joint injection were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE LEFT SHOULDER WITHOUT DYE: 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), Shoulder Chapter, Magnetic Resonance Imaging (MRI).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Magneti Resonance Imaging.

Decision rationale: Shoulder imaging may be considered for a patient whose limitations due to consistent symptoms have persisted for one month or more in cases where surgery is being considered for a specific anatomic defect (e.g., a full-thickness rotator cuff tear) or to further evaluate the possibility of potentially serious pathology, such as a tumor. Magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because it demonstrates soft tissue anatomy better. Indications for MRI of the left shoulder are acute shoulder trauma, suspect rotator cuff tear/impingement in patients over 40 years of age with normal plain radiographs, and when instability/labral tear are suspected in sub acute shoulder pain. In this case the patient left shoulder is not anticipated and serious pathology is not suspected. There is no acute trauma. Medical necessity has not been established. The request should not be authorized.

ELECTROMYOGRAM (EMG) OF THE LEFT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow, Tests For Cubital Tunnel Syndrome.

Decision rationale: Cubital tunnel syndrome is also known as ulnar nerve entrapment. The ulnar nerve is commonly trapped at the elbow. The most common symptom is paresthesias in the ring and little fingers. Weakness/atrophy of ulnar hand intrinsics and interosseous muscles is a late sign. Abnormalities on EMG are considered typical of more advanced cases. In this case the EMG was ordered to rule out cubital tunnel syndrome. Insufficient data exists to allow firm evidence-based conclusions regarding the effectiveness of any tests for cubital tunnel syndrome, as the evidence base is small and heterogeneous. In addition the examination for sensory function is incomplete and the motor examination is absent. The documentation in the medical record is insufficient to support the diagnosis of cubital tunnel syndrome. The request should not be authorized.

NERVE CONDUCTION VELOCITY (NCV) STUDY OF THE LEFT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow, Tests For Cubital Tunnel Syndrome.

Decision rationale: Cubital tunnel syndrome is also known as ulnar nerve entrapment. The ulnar nerve is commonly trapped at the elbow. The most common symptom is paresthesias in the ring and little fingers. Weakness/atrophy of ulnar hand intrinsics and interosseous muscles is a late sign. Abnormalities on EMG are considered typical of more advanced cases. In this case the nerve conduction velocity was ordered to rule out cubital tunnel syndrome. Insufficient data exists to allow firm evidence-based conclusions regarding the effectiveness of any tests for cubital tunnel syndrome, as the evidence base is small and heterogeneous. In addition the examination for sensory function is incomplete and the motor examination is absent. The documentation in the medical record is insufficient to support the diagnosis of cubital tunnel syndrome. The request should not be authorized.

SECOND S1 JOINT INJECTION ON THE LEFT SIDE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis, Sacroiliac Joint Blocks.

Decision rationale: Sacroiliac joint blocks are recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below. 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). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular ligaments). 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. Etiology includes degenerative joint disease, joint laxity, and trauma (such as a fall to the buttock). The main cause is SI joint disruption from significant pelvic trauma. Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction. These include Cranial Shear Test, Extension Test, Flamingo Test, Fortin Finger Test, Gaenslen's Test, Gillet's Test (One Legged-Stork Test), Patrick's Test (FABER), Pelvic Compression Test, Pelvic Distraction Test, Pelvic Rock Test, Resisted Abduction Test (REAB);, Sacroiliac Shear Test, Standing Flexion Test, Seated Flexion Test, and Thigh Thrust Test (POSH). Imaging studies are not helpful. It has been questioned as to whether SI joint blocks are the "diagnostic gold standard." The block is felt to show low sensitivity, and discordance has been noted between two consecutive blocks (questioning validity). There is also concern that pain relief from diagnostic blocks may be confounded by infiltration of extra-articular ligaments, adjacent muscles, or sheaths of the nerve roots themselves. There is limited research suggesting therapeutic blocks offer long-term effect. There should be evidence of a trial of aggressive conservative treatment (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatory) as well as evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block. If helpful, the blocks may be repeated; however, the frequency of these injections should be limited with attention placed on the comprehensive exercise program. Criteria for the use of sacroiliac blocks: 1. the history and

physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). 2. Diagnostic evaluation must first address any other possible pain generators. 3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. 4. Blocks are performed under fluoroscopy. 5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. 6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period. 7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. 8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block. 9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. In this case there is no documentation of at least three positive examination findings required for the diagnosis of sacroilitis. The patient had previous injection, which improved tolerance to pain and walking 30% time. The response should show at least 70% improvement. Medical necessity has not been established. The request should not be authorized.