

Case Number:	CM14-0041275		
Date Assigned:	06/20/2014	Date of Injury:	02/10/2013
Decision Date:	07/18/2014	UR Denial Date:	02/22/2014
Priority:	Standard	Application Received:	03/14/2014

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 Family Medicine and is licensed to practice in New Jersey. 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 worker is a 37 year old male who was injured on 12/10/13 after slipping and falling and hyperextending his right leg. He was first diagnosed with right hamstring muscle strain/sprain after he complained of right hamstring and right buttock area. He was first recommended gentle stretches and exercises and was prescribed NSAIDs, Tylenol, opioids, and muscle relaxants as needed. He was seen again on 12/16/13 complaining of the same pain as before rated at a 9/10 on the pain scale, and examination revealed tenderness at hamstring. X-ray of pelvis was done and was normal. He was then recommended physical therapy and modified duty. He reported to the physical therapist that his muscle soreness went away after 1 weeks but the right buttock pain got worse after waking up the morning of 1/7/14. On 1/9/14 he reported back to his primary treating physician complaining of his same pain 9/10 on pain scale but this time with numbness and tingling to the right lower extremity. Physical examination revealed normal gait, but with guarded motions, tenderness along right lower back and right buttock where it was most tender. His coccyx was also tender. The right seated leg raise test was positive and dorsiflexion testing was strongly positive on both sides, but normal reflexes and sensation of the legs was noted. He then was diagnosed with sciatica in addition to his primary diagnosis. X-rays were done on his lumbar spine and coccyx which were essentially normal. He reported later to his physical therapist on 1/13/14 that the bottom of his right foot was numb and was less sensitive to temperature, although the buttock pain was less (5/10). He was seen by his treating physician on 1/14/14 reporting his numbness and tingling has lessened with physical therapy and that his Motrin and muscle relaxant use helped the pain. MRI was ordered and done on 1/22/14 revealing bulging disc close to or touching L5 nerve root, mild right joint facet arthropathy at L4-L5 level, and pars defect (possible) at L5. He was seen by a pain specialist on 1/24/14 complaining of acute progressive pain in his lower back and right hip which radiates down to his right leg with

associated numbness, tingling, and weakness into the leg and foot. Examination revealed decreased strength, sensation and reflexes on right leg and foot and the straight leg raise test was positive on the right. He was then diagnosed with lumbar radiculopathy and low back pain. An EMG/NCV test was recommended, Neurontin, more physical therapy, TENS unit, and a lumbar epidural injection. He was also seen by his primary physician on 2/14/14 who recommended he see a psychologist as he reported anxiety and headaches due to stress of work and his pain, but the worker was hesitant to do such.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV studies of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- EMG/NCV.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The MTUS ACOEM Guidelines state that for lower back complaints, nerve testing may be considered when the neurological examination is less clear for symptoms that last more than 3-4 weeks with conservative therapy. In the case of this worker, it appears to be a clear diagnosis of sciatica and lumbar radiculopathy based on presentation and physical examination of more than one physician and therefore would not aid in the diagnosis or change the treatment plan as long as he is responding to physical therapy which was still in its early phases at the time. The EMG/NCV studies of the lower extremities are not medically necessary in this case.

Referral to pain management psychologist: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

Decision rationale: The MTUS ACOEM Guidelines suggest that a specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist while common psychiatric conditions such as mild depression be referred only after symptoms continue for more than 6-8 weeks. Issues regarding work stress and person-job fit may be handled effectively with talk therapy through a psychologist or other mental health professional. Patients with more serious conditions may need a referral to a psychiatrist for medical therapy. In the case of this worker, seeing a psychologist may very well be a useful approach as long as the worker is willing to do so and as long as he experiences any stress or

anxiety related to his work or pain. The previous reviewer disregarded the difference between the guideline's recommendations for psychologist referral vs. psychiatrist referral, and in this case the referral to the psychologist is medically necessary.

Transforaminal lumbar epidural steroid injection at right L4 and L5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: The MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of lumbar radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and can offer short term pain relief, but use should be in conjunction with other rehab efforts, including continuing a home exercise program. The criteria as stated in the MTUS Guidelines for epidural steroid injection use for chronic pain includes the following: 1. radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, 2. Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants), 3. Injections should be performed using fluoroscopy for guidance, 4. If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections, 5. no more than two nerve root levels should be injected using transforaminal blocks, 6. no more than one interlaminar level should be injected at one session, 7. in the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, and 8. Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase, and instead only up to 2 injections are recommended. Since the worker in this case was in the process still of doing physical therapy and responding to this treatment method, the epidural at that stage would have been premature and further physical therapy alone may be most appropriate according to the guidelines. Therefore, the epidural is not medically necessary.