

Case Number:	CM14-0043193		
Date Assigned:	06/20/2014	Date of Injury:	01/31/2011
Decision Date:	12/30/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/17/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 patient is a 63-year-old female with a date of injury of 01/31/2011. The listed diagnoses are: 1. Chronic pain. 2. Cervicalgia. 3. Lumbago. 4. Radiculitis, lumbar. According to progress report 02/13/2014, the patient presents with pain in the neck, shoulder, scapula, and low back pain. The patient reports "sciatica type pain at the right buttock to posterior lower extremities (LE) to ankle coming down to a minimal degree." The patient is status post right-sided L4-L5 facet cyst aspiration and L4-L5 and L5-S1 facet injection procedure done on 10/10/2013 in which the patient reported 40% to 60% relief from procedure. Physical examination of the lumbar spine revealed tenderness to palpation over the right lumbar paraspinals. Range of motion was decreased in all planes. The patient noted numbness in the bilateral feet. Deep tendon reflexes were 2+ and symmetric in bilateral lower extremity. The provider discusses an MRI of the lumbar spine from 02/11/2013 that revealed bilateral L4-L5 spondylolisthesis and a right synovial cyst compressing the right L5 and S1 nerve root. The MRI report was not provided for my review. Treatment plan includes right L4-L5 and L5-S1 facet joint injection and bilateral L4-L5 and L5-S1 TFESI, MRI of the lumbar spine, and electromyogram/ nerve conduction velocity (EMG/NCV) of the lower extremities. Utilization review denied the request on 02/25/2014. Treatment report from 12/10/2013 and 02/13/2014 were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4-5 and L5-S1 facet joint injection and bilateral L4-5 and L5-S1 transforaminal epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESI) Page(s): 46, 47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet Joint Diagnostic Blocks (Injections).

Decision rationale: The patient presents with neck, shoulders, scapula, and low back pain. The patient reports radiating pain to the right buttock to the posterior lower extremity. The current request is for a right L4-L5 and L5-S1 facet joint injection and bilateral L4-L5 and L5-S1 transforaminal epidural steroid injection. MTUS Guidelines page 46 and 47 recommend ESI as an option for treatment of radicular pain defined as pain in the dermatomal distribution with corroborative findings of radiculopathy. For facet blocks, ACOEM Guidelines do not support facet joint injections for treatments, but does discuss dorsal medial branch blocks and RF ablations following that on page 300 and 301. For more thorough discussion of facet joint diagnostic evaluations, ODG Guidelines is consulted. ODG Guidelines does support facet diagnostic evaluations for patient presenting with paravertebral tenderness with non-radicular symptoms and no more than 2 levels bilaterally are to be injected. In this case, the treating physician is requesting an ESI and facet injection, both contradicting each other. ESI is for treatment of radiculopathy. Facet blocks are for treatment of paravertebral tenderness with non-radicular symptoms. In regards to the bilateral L4-L5 and L5-S1 transforaminal epidural steroid injection, the patient on examination does present with some radicular symptoms, but straight leg raise was noted as negative and there was no documentation of sensory changes. For the facet block, the patient has radicular symptoms and a diagnosis of lumbar radiculitis. Facet blocks are only supported for non-radicular symptoms. Therefore, right L4-5 and L5-S1 facet joint injection and bilateral L4-5 and L5-S1 transforaminal epidural steroid injection are not medically necessary and appropriate.

MRI lumbar spine to re-evaluate stenosis and facet cyst: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) chapter, Urine Drug Testing (UDT).

Decision rationale: This patient presents with neck, shoulder, sciatica, scapula, and low back pain. The low back pain radiates to the right buttock to posterior lower extremity. The current request is for MRI of lumbar spine to reevaluate stenosis and facet cyst. For the MRI of the lumbar spine, ACOEM Guidelines page 303 states "unequivocal objective findings that identify

specific nerve compromise on the neurological examination is sufficient evidence to warrant imaging in patients who do not respond well to treatment and who would consider surgery as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." For this patient's now chronic condition with radicular symptoms and weakness, ODG guidelines provide a good discussion. ODG under its low back chapter recommends obtaining an MRI for uncomplicated low back pain with radiculopathy after 1 month of conservative therapy, sooner if severe or progressive neurologic deficit. The medical records indicate that the patient underwent an MRI of the lumbar spine on 02/11/2013 that revealed "bilateral L4-L5 facet joint injection with spondylolisthesis and a right synovial cyst compressing the right L5 and S1 nerve root." On 10/10/2013, the patient underwent a right-sided L4-L5 facet cyst aspiration. The treater is requesting for updated imaging to re-evaluate the facet cyst. In this case, post-operative MRI for evaluation is supported. Recommendation is for authorization.

Electromyography (EMG) bilateral lower extremity to evaluate radiculopathy: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Electrodiagnostic Testing (EMG/NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, Electrodiagnostic Studies (EDS).

Decision rationale: This patient presents with neck, shoulder, sciatica, scapula, and low back pain. The low back pain radiates to the right buttock to posterior lower extremity. The current request is for electromyography (EMG) of bilateral lower extremities to evaluate radiculopathy. ACOEM Guidelines page 303 states, "Electromyography (EMG), including H-reflex test, may be useful to identify subtle, focal neurologic dysfunction in patients with low back pain symptoms lasting more than 3 or 4 weeks." ODG Guidelines under its low back chapter has the following regarding EMG studies, "EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy after 1 month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious." In this case, it appears that there has been no prior EMG/NCV testing and given the patient's continued complaints of pain further diagnostic testing may be useful to obtain unequivocal evidence of radiculopathy. Therefore, electromyography (EMG) bilateral lower extremity to evaluate radiculopathy is medically necessary and appropriate.

Nerve conduction velocity (NCV) bilateral lower extremity to evaluate radiculopathy:
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) - Electrodiagnostic Testing (EMG/NCS).

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 Chapter, NCV.

Decision rationale: This patient presents with neck, shoulder, sciatica, scapula, and low back pain. The low back pain radiates to the right buttock to posterior lower extremity. The current request is for nerve conduction velocity (NCV) of bilateral lower extremities to evaluate radiculopathy. The MTUS and ACOEM do not discuss NCS. However, an ODG guideline under its low back chapter has the following regarding NCV studies: "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013)" Review of the medical file does not indicate that the patient has had an NCV in the past. In regard to NCV studies, ODG guidelines states, Nerve conduction studies (NCS) are not recommended for low back conditions. This patient presents with low back pain and right leg pain and the provider does not raise any suspicion for peripheral neuropathy, plexopathy or other neuropathies other than radicular symptoms to consider NCV studies. Therefore, nerve conduction velocity (NCV) bilateral lower extremity to evaluate radiculopathy is not medically necessary and appropriate.