Case Number:	CM14-0120091		
Date Assigned:	09/24/2014	**Date of Injury:**	03/06/2014
Decision Date:	02/20/2015	**UR Denial Date:**	07/15/2014
Priority:	Standard	**Application Received:**	07/30/2014

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. 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: Colorado
Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

32 year old female with date of injury 3/6/2014 continues care with treating physician. Patient complaints include low back pain radiating to legs and left hand neuritis. Patient has participated in passive physical therapy with minimal relief. She attempted active physical therapy which aggravated her condition. She has tried massage and chiropractic with little relief. The records indicate patient is maintained on combination of medications, but pain is not well controlled and function is severely limited by pain. Physical findings include decreased lumbar range or motion and tenderness in lumbar region, and decreased sensation in S1 dermatome bilaterally, as well as decreased sensation in left 5th digit. Treating physician requests L3-L4 epidural steroid injection with post-procedure physical therapy, and EMG/NCV of bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy to Lumbar 3x2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: Per the MTUS Guidelines, Physical Therapy is recommended in specific circumstances. Passive therapies have been shown to be beneficial in early stages / acute pain, to help control pain, inflammation, and swelling and to promote healing of soft tissue injuries. While passive therapies can be helpful short term, active therapies have shown clinically significant improvement long term. Active therapies require energy expenditure on the part of the patient and may require supervision, but are expected to be continued as home exercise program as well. Per the guidelines, Physical Therapy can be recommended in specific frequency and duration for specific conditions: Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Per the records supplied for the patient of concern, patient has previously been unable to tolerate active physical therapy as it aggravated her back pain. The current physical therapy requested is for post-procedure (Epidural steroid injection) physical therapy. As patient has previously been unable to tolerate physical therapy, and as the procedure (L3-L4 epidural steroid injection) is not considered to be medically necessary, this specific request for Physical Therapy is not medically necessary.

Lumbar Epidural Steroid Injection at L3-L4: Upheld

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

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

Decision rationale: Per the MTUS,epidural steroid injections are recommended as an option for treatment of radicular pain. Current guidelines indicate no more than 2 epidural steroid injections are generally needed to achieve some relief of lumbosacral pain, and no evidence suggests relief is lasting. If initial epidural steroid injection does not provide at least 50% reduction in pain as well as some improvement in function, then additional injections are not indicated. Because pain relief is short term and no long-term effects on function have been identified, epidural steroid injections are recommended as part of a program including other therapies such as exercise program. There is insufficient evidence to recommend cervical epidural steroid injections to treat cervical radicular pain. Per MTUS Guidelines, the following criteria should be used to determine which patient may benefit from epidural steroid injection: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections For the patient of concern, the physical exam and EMG/NCV of lower extremities support the diagnosis of lumbar radiculopathy, specifically L5 and S1, not L3-L4. The request is for Lumbar epidural steroid injection at L3-L4 which is the level of disc protrusion on MRI, but is not the level related to radiculopathy. As the level of radiculopathy is not L3-L4, the request for L3-L4 epidural steroid injection is not medically indicated.

EMG to Bilateral Upper Extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 807-808, 847-848.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not address the use of EMG/NCS as diagnostics, so the ACOEM Guidelines were consulted. As EMG and NCS are recommended in combination, the rationale for EMG is the same as that for NCS. Electrodiagnostic studies, comprised of EMG and NCS, are recommended when CT or MRI is non-diagnostic and /or patient continues to have symptoms, suggestive of neurological compromise, that do not respond to treatment. If suspected radicular pain fails to resolve or reaches a plateau after 4-6 weeks, which would allow time to develop new abnormalities on testing, then NCS, with needle EMG component if radiculopathy suspected, would be indicated. NCS would also be indicated if another condition, in addition to or instead of radiculopathy, is suspected based on history and/or physical. Some clinicians would wait to test patients with NCV/EMG until after patient failed a steroid injection as a diagnostic and therapeutic trial. For the patient of concern, there is documentation of physical finding of possible neurological compromise with decreased sensation in left 5th digit. The records do not indicate any other neurologic abnormalities of the upper extremities, and no abnormality or pain in the right upper extremity. There is no documentation of CT or MRI related to left upper extremity symptoms. Without any evidence of neurological abnormality or even pain in the right upper extremity, EMG would not be indicated for the right upper extremity. While EMG may be indicated for the left upper extremity, the request is for both extremities, so the request for EMG of the bilateral upper extremities is not medically necessary.

NCV to Bilateral Upper Extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 807-808, 847-848.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not address the use of EMG/NCV as diagnostics, so the ACOEM Guidelines were consulted. As EMG and NCV are recommended in combination, the rationale for EMG is the same as that for NCV. Electrodiagnostic studies, comprised of EMG and NCV, are recommended when CT or MRI is non-diagnostic and /or patient continues to have symptoms, suggestive of neurological compromise, that do not respond to treatment. If suspected radicular pain fails to resolve or reaches a plateau after 4-6 weeks, which would allow time to develop new abnormalities on testing, then NCV, with needle EMG component if radiculopathy suspected, would be indicated. NCV would also be indicated if another condition, in addition to or instead of radiculopathy, is suspected based on history and/or physical. Some clinicians would wait to test patients with NCV/EMG until after patient failed a steroid injection as a diagnostic and therapeutic trial. For the patient of concern, there is documentation of physical finding of decreased sensation in left 5th digit. The records do not indicate any other neurologic abnormalities of the left upper extremity, and no abnormality or pain in the right upper extremity. There is no documentation of CT or MRI related to left upper extremity symptoms. Without any evidence of neurological abnormality or even pain in the right upper extremity, NCV would not be indicated for the right upper extremity. While NCV may be indicated for the left upper extremity, the request is for both extremities, so the request for NCV of the Bilateral Upper extremities is not medically necessary.