

Case Number:	CM14-0120164		
Date Assigned:	08/06/2014	Date of Injury:	07/14/2011
Decision Date:	04/01/2015	UR Denial Date:	07/07/2014
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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 (IW) is a 35 year old female who sustained an industrial injury on 07/14/2011. She has reported pain in the low back, neck and elbows that is aggravated by work and walking. Diagnoses include lumbago, low back pain, cervical pain /cervicalgia, sacroiliac joint dysfunction, long use of medications, trochanteric bursitis, and lateral epicondylitis. Treatment to date includes medications including Flexeril 10 mg, Norco 10mg-325 mg tablets, and oxycodone-acetaminophen 10mg-325 mg tablets, and random drug screening. A progress note from the treating provider dated 06/09/2014 indicates decreased flexion, extension, rotation and left and right lateral bending in the cervical spine. The bilateral upper extremities had tendon sheath swelling, tender lateral epicondyle and pain with resisted wrist extension. The lower extremities examination was benign, the spine ribs and pelvis had tenderness at the lumbar spine, facet joints, decreased flexion, extension and decreased lateral bending bilaterally. The right and left sacroiliac joints had tenderness to palpation as did the left and right greater trochanters. Treatment plan included Bilateral Epicondyle Corticosteroid Injection, 1 Left Side S1 Joint Injection and Trochanteric Bursa Injection, Electromyography of the Bilateral Upper Extremities x 2, and Electromyography /Nerve Conduction Study of the bilateral upper extremities. On 07/07/2014 Utilization Review non-certified a request for 1 Bilateral Epicondyle Corticosteroid Injection, noting there is no previous indication of non-invasive physical medicine being attempted or failed for the patient's elbow complaints. The MTUS, ACOEM Guidelines were cited. On 07/07/2014 Utilization Review non-certified a request for 1 Left Side S1 Joint Injection and Trochanteric Bursa Injection, noting there were no specific objective findings of

trochanteric bursitis or hip osteoarthritis. The Official Disability Guidelines were cited. On 07/07/2014 Utilization Review non-certified a request for Electromyography of the Bilateral Upper Extremities x 2 noting there were no documented neurologic dysfunction or deficiencies on examination. The MTUS, ACOEM Guidelines were cited. On 07/07/2014 Utilization Review non-certified a request for Nerve Conduction Study of the Bilateral Upper Extremities x 2, noting the lack of neurologic dysfunction or deficiency on exam. The MTUS, ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Left Side S1 Joint Injection and Trochanteric Bursa Injection: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip and Pelvis (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back Chapter under SI joint injections.

Decision rationale: The patient presents with low back, hip, bilateral elbows, shoulder, and neck pain that radiate down bilateral arms. Patient's pain is 8/10 with and 10/10 without medication. The request is for 1 LEFT SIDE S1 JOINT INJECTION AND TROCHANTERIC BURSA INJECTIONS. The RFA provided is dated 07/02/14. Physical examination to the head and neck revealed decreased flexion, extension, rotation and left and right lateral bending in the cervical spine. The bilateral upper extremities had tendon sheath swelling, tender lateral epicondyle and pain with resisted wrist extension. The patient reports hyposense to left upper extremity in the C5 and C8 dermatomes, right lower extremity lateral thigh, lateral calf, and left lower extremity anterior thigh with light touch. The lower extremities examination was benign, the spine ribs and pelvis had tenderness at the lumbar spine, facet joints, decreased flexion, extension and decreased lateral bending bilaterally. The right and left sacroiliac joints had tenderness to palpation as did the left and right greater trochanters. Patient's diagnosis on 06/09/14 included lumbago, low back pain, cervical pain /cervicalgia, sacroiliac joint dysfunction, long use of medications, trochanteric bursitis, and lateral epicondylitis. Per medical report dated 02/06/14, the patient underwent cervical MRI on 01/15/14 that revealed multilevel spondylosis, congenial spinal canal narrowing, central canal stenosis C3-C4 through C6-C7, disk osteophyte complex C4-C5, and borderline Chiari malformation grade 1. The pelvis MRI on the same date was essentially negative. Patient is temporarily totally disabled. Regarding trochanteric bursa injections, ODG guidelines state "Recommended for trochanteric pain, corticosteroid injection is safe and highly effective, with a single corticosteroid injection often providing satisfactory pain relief (level of evidence, C)." ODG guidelines, Low Back Chapter under SI joint injections states: " Treatment: 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-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac injury

and/or disease prior to a first SI joint block." ODG further states that, "The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed." "Diagnosis: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: 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; Thigh Thrust Test (POSH). Review of report, show no evidence of prior trochanteric bursa or S1 joint injections. The treater also states that the patient has failed conservative treatments including physical therapy, medication, rest and home exercise program more than 6 weeks. Given the patient's diagnosis of trochanteric bursitis, a diagnostic trochanteric bursa injection is within ODG guidelines; however, guidelines recommend sacroiliac joint injections to patients who have failed conservative care and have three positive orthopedic tests. In this case, the patient does not present with hip osteoarthritis. There are no documented positive orthopedic tests. Therefore, the request IS medically necessary.

Electromyography of the Bilateral Upper Extremities x 2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official disability guidelines Neck chapter, EMG NVC studies.

Decision rationale: The patient presents with low back, hip, bilateral elbows, shoulder, and neck pain that radiate down bilateral arms. Patient's pain is 8/10 with and 10/10 without medication. The request is for ELECTROMYOGRAPHY OF THE BILATERAL UPPER EXTREMITIES X2. The RFA provided is dated 07/02/14. Physical examination to the head and neck revealed decreased flexion, extension, rotation and left and right lateral bending in the cervical spine. The bilateral upper extremities had tendon sheath swelling, tender lateral epicondyle and pain with resisted wrist extension. The patient reports hyposense to left upper extremity in the C5 and C8 dermatomes, right lower extremity lateral thigh, lateral calf, and left lower extremity anterior thigh with light touch. The lower extremities examination was benign, the spine ribs and pelvis had tenderness at the lumbar spine, facet joints, decreased flexion, extension and decreased lateral bending bilaterally. The right and left sacroiliac joints had tenderness to palpation as did the left and right greater trochanters. Patient's diagnosis on 06/09/14 included lumbago, low back pain, cervical pain /cervicalgia, sacroiliac joint dysfunction, long use of medications, trochanteric bursitis, and lateral epicondylitis. Per medical report dated 02/06/14, the patient underwent cervical MRI on 01/15/14 that revealed multilevel spondylosis, congenital spinal canal narrowing, central canal stenosis C3-C4 through C6-C7, disk osteophyte complex C4-C5, and borderline Chiari malformation grade 1. The pelvis MRI on the same date was essentially negative. Patient is temporarily totally disabled. The ACOEM guidelines page 262 on EMG/NCV states that appropriate studies EDS: may help differentiate between CTS and other condition such as cervical radiculopathy. In addition, ODG states that electrodiagnostic testing includes testing for nerve conduction velocities. NCV: and possibly the addition of

electromyography. EMG: Electromyography and nerve conduction velocities including H-reflex test may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms or both, lasting more than 3 or 4 weeks. ACOEM guidelines Ch11 page 262 states that "tests may be repeated later in the course of treatment if symptoms persist." In this case, there is no reference to prior EMG and the patient continues with significant upper extremity pain. There is documentation of subjective radicular complaints as well as upper extremity numbness and tingling for which EMG may be appropriate. However, the request is for two sets of studies, as indicated by "X2" request. The treater does not explain why 2 sets of EMGs are needed. The request IS NOT medically necessary.

Nerve Conduction Study of the Bilateral Upper Extremities x 2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official disability guidelines Neck chapter, EMG NVC studies.

Decision rationale: The patient presents with low back, hip, bilateral elbows, shoulder, and neck pain that radiate down bilateral arms. Patient's pain is 8/10 with and 10/10 without medication. The request is for ELECTROMYOGRAPHY OF THE BILATERAL UPPER EXTREMITIES X2. The RFA provided is dated 07/02/14. Physical examination to the head and neck revealed decreased flexion, extension, rotation and left and right lateral bending in the cervical spine. The bilateral upper extremities had tendon sheath swelling, tender lateral epicondyle and pain with resisted wrist extension. The patient reports hyposense to left upper extremity in the C5 and C8 dermatomes, right lower extremity lateral thigh, lateral calf, and left lower extremity anterior thigh with light touch. Patient's diagnosis on 06/09/14 included lumbago, low back pain, cervical pain /cervicalgia, sacroiliac joint dysfunction, long use of medications, trochanteric bursitis, and lateral epicondylitis. Per medical report dated 02/06/14, the patient underwent cervical MRI on 01/15/14 that revealed multilevel spondylosis, congenital spinal canal narrowing, central canal stenosis C3-C4 through C6-C7, disk osteophyte complex C4-C5, and borderline Chiari malformation grade 1. Patient is temporarily totally disabled. The ACOEM guidelines page 262 on EMG/NCV states that appropriate studies. EDS: may help differentiate between CTS and other condition such as cervical radiculopathy. In addition, ODG states that electrodiagnostic testing includes testing for nerve conduction velocities. NCV: and possibly the addition of electromyography. EMG: Electromyography and nerve conduction velocities including H-reflex test may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms or both, lasting more than 3 or 4 weeks. ACOEM guidelines Ch11 page 262 states that "tests may be repeated later in the course of treatment if symptoms persist." The ACOEM guidelines page 262 on EMG/NCV states that appropriate studies. EDS: may help differentiate between CTS and other condition such as cervical radiculopathy. In addition, ODG states that electrodiagnostic testing includes testing for nerve conduction velocities. NCV: and possibly the addition of electromyography. EMG: Electromyography and nerve conduction velocities including H-reflex test may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms or both, lasting more than 3 or 4 weeks. ACOEM guidelines Ch11 page

262 states that "tests may be repeated later in the course of treatment if symptoms persist." In this case, there is no reference to prior NCS and the patient continues with significant upper extremity pain. There is documentation of subjective radicular complaints as well as objective physical findings. However, the request is for two sets of NCV studies, which is not indicated. The request IS NOT medically necessary.

1 Bilateral Epicondyle Corticosteroid Injection: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 18, 25.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Elbow chapter, Injections (corticosteroid).

Decision rationale: The patient presents with low back, hip, bilateral elbows, shoulder, and neck pain that radiate down bilateral arms. Patient's pain is 8/10 with and 10/10 without medication. The request is for 1 BILATERAL EPICONDYLE CORTICOSTEROID INJECTION. The RFA provided is dated 07/02/14. Physical examination to the head and neck revealed decreased flexion, extension, rotation and left and right lateral bending in the cervical spine. The bilateral upper extremities had tendon sheath swelling, tender lateral epicondyle and pain with resisted wrist extension. The patient reports hyposense to left upper extremity in the C5 and C8 dermatomes, right lower extremity lateral thigh, lateral calf, and left lower extremity anterior thigh with light touch. The lower extremities examination was benign, the spine ribs and pelvis had tenderness at the lumbar spine, facet joints, decreased flexion, extension and decreased lateral bending bilaterally. The right and left sacroiliac joints had tenderness to palpation as did the left and right greater trochanters. Patient's diagnosis on 06/09/14 included lumbago, low back pain, cervical pain /cervicalgia, sacroiliac joint dysfunction, long use of medications, trochanteric bursitis, and lateral epicondylitis. Per medical report dated 02/06/14, the patient underwent cervical MRI on 01/15/14 that revealed multilevel spondylosis, congenial spinal canal narrowing, central canal stenosis C3-C4 through C6-C7, disk osteophyte complex C4-C5, and borderline Chiari malformation grade 1. The pelvis MRI on the same date was essentially negative. Patient is temporarily totally disabled. Regarding Cortisone injections for epicondylar pain, ODG states that they are under study. ODG states: While there is some benefit in short-term relief of pain, patients requiring multiple corticosteroid injections to alleviate pain have a guarded prognosis for continued non-operative management. Corticosteroid injection does not provide any long-term clinically significant improvement in the outcome of epicondylitis, and rehabilitation should be the first line of treatment in acute cases, but injections combined with work modification may have benefit. A recent clinical trial of treatments for epicondylitis found that, after 12 months, the success rate for physical therapy, 91%, was significantly higher than injection, 69%, but only slightly higher than in the wait-and-see group 83%. ACOEM guidelines states corticosteroid injections have been shown to be effective, at least in the short term; however, the evidence on long-term effects is mixed, some studies show high recurrence rate among injection groups. ACOEM considers the injections optional treatment. In regards to the request for what appears to be this patient's first Cortisone injection, the request appears reasonable. ODG and ACOEM do support trial of injections for short term

relief to allow recovery from exercises and therapy. The request IS medically necessary. In regards to the request for what appears to be this patient's first Cortisone injection, the request appears reasonable. ODG and ACOEM do support trial of injections for short-term relief to allow recovery from exercises and therapy. The request IS medically necessary.