

<b>Case Number:</b>	CM15-0005333		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	10/08/2010
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	12/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2015

### 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: North Carolina

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:

The 52 year old female injured worker suffered and industrial injury on 10/8/2010. The diagnoses were cervicgia, cervical radiculopathy, cervical facet dysfunction, shoulder pain, lumbago, lumbar radiculopathy, lumbar disc dysfunction and carpal tunnel syndrome. The diagnostic studies were cervical magnetic resonance imaging, and electromyography. The treatments were epidural steroid injections, left shoulder arthroscopy, physical therapy, acupuncture, chiropractic therapy and TENS. The treating provider reported neck and low back pain that is constant, dull, throbbing with tingling and numbness in both hands. The low back pain radiates to the left leg with numbness and tingling. The injured worker reported weakness to the left leg. On exam there was reduces range of motion of the cervical spine and shoulders. The straight leg raise was positive producing left leg pain. There was decreased sensation to left ankle and foot, bilateral hands. There was also weakness to the bilateral upper extremities. The Utilization Review Determination on 12/10/2014 non-certified: 1.EMG/ NCS (Electromyography/Nerve Conduction Study) Upper Extremities, citing ACOEM. 2. EMG/ NCS (Electromyography/Nerve Conduction Study) Lower Extremities, citing ACOEM. 3. Transforaminal Lumbar Epidural Steroid Injection, citing MTUS.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/ NCS (Electromyography/Nerve Conduction Study) Upper Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

**Decision rationale:** The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag Physiologic evidence of tissue insult or neurologic dysfunction Failure to progress in a strengthening program intended to avoid surgery Clarification of the anatomy prior to an invasive procedure Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore the request is not certified.

**EMG/ NCS (Electromyography/Nerve Conduction Study) Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305, 309.

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

**Decision rationale:** The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-

positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. There is no objective evidence of neurologic dysfunction or unequivocal objective findings that identify nerve compromise as documented in the provided physical exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore the request is not certified.

**Transforaminal Lumbar Epidural Steroid Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESIs Page(s): 46.

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

**Decision rationale:** The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 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. The patient has the documentation of low back pain and lumbar radiculopathy however there is no included corroboration by imaging studies or EMG. For these reasons criteria as set forth above per the California MTUS have not been met. The request is not certified.