

<b>Case Number:</b>	CM15-0007690		
<b>Date Assigned:</b>	01/27/2015	<b>Date of Injury:</b>	09/06/2013
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 is a 50 year old male with an industrial injury dated 09/06/2013. His diagnoses include lumbosacral strain/sprain, lumbago, and degeneration of the lumbosacral/lumbar disc. Diagnostic testing has included a MRI of the lumbar spine (12/11/2013) which showed a non-acute compression fracture of the inferior anterior aspect of L1. He has been treated with analgesic medications for several months. In a progress note dated 12/22/2014, the treating physician reports no substantial changes despite treatment. The objective examination revealed sacroiliac joint tenderness on the right side, and positive stress sciatic test. A prior exam (11/24/2014) reported complaints of lower back pain rated 7/10 as well as the lateral aspect of the right leg combined with numbness extending into the ankle region. Objective findings revealed mild to moderate tenderness to the upper lumbar spine and the soreness and tenderness of the right lower paralumbar and right sciatic outlet, and decreased range of motion in the lumbar spine. The treating physician is requesting Si joint injections, EMG of the bilateral lower extremities, repeat MRI of the lumbar spine and physical therapy for the lumbar spine which were denied by the utilization review. On 12/05/2014, Utilization Review non-certified a request for right SI joint injection, noting the absence of physical exam findings. The ODG guidelines were cited. On 12/05/2014, Utilization Review non-certified a request for repeat MRI of the lumbar spine, noting the absence of physical exam findings. The ACOEM Guidelines were cited. On 12/05/2014, Utilization Review non-certified a request for bilateral EMG (Electromyography) of the lower extremities, noting the absence of physical exam findings. The ACOEM Guidelines were cited. On 12/05/2014, Utilization Review non-certified a

request for physical therapy 2 times 6 for the lumbar spine, noting the absence of physical exam findings. The MTUS Guidelines were cited. On 01/13/2015, the injured worker submitted an application for IMR for review of right SI joint injection, repeat lumbar MRI, bilateral EMG of the lower extremities, and physical therapy 2 times 6 for the lumbar spine.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Right SI (sacroiliac) joint injection: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Sacroiliac joint injections

**Decision rationale:** Sacroiliac joint injections (SJI) are recommended as an option if the patient has failed at least 4-6 weeks of aggressive conservative therapy. In this case, physical exam demonstrated right SIJ tenderness. However, there was no clear documentation of failure of 4-6 weeks of aggressive conservative therapy. Medical necessity of the requested SIJ injection has not been established. The requested medication is not medically necessary.

#### **Lumbar MRI (Magnetic Resonance Imaging): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS, MRI Lumbar Page(s): 304.

**Decision rationale:** According to California MTUS Guidelines, MRI of the the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for a repeat MRI of the lumbar spine. The documentation indicates that the claimant had an MRI of the lumbar spine on 12/11/2013. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, there is no specific indication for a repeat MRI of the lumbar spine. Medical necessity for the requested MRI has not been established. The requested imaging is not medically necessary.

#### **EMG (Electromyography) study of the bilateral lower extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Nerve Conduction Velocity Testing (2010)

**Decision rationale:** There is no documentation provided necessitating EMG testing of both lower extremities. According to the ODG, EMG (Electromyography) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. In this case, there were no physical exam findings provided in the records. Medical necessity for the requested item has not been established, as guideline criteria have not been met. The requested item is not medically necessary.

**Lumbar physical therapy 2 times a week for 6 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Page(s): 98. Decision based on Non-MTUS Citation Physical Therapy, Lumbar Strain

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of low back pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, there are no physical exam findings provided. The guideline criteria have not been met. Medical necessity for the requested service has not been established. The requested item is not medically necessary.