

Case Number:	CM15-0133269		
Date Assigned:	07/21/2015	Date of Injury:	11/25/2013
Decision Date:	08/18/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/09/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 48 year old male, who sustained an industrial injury on 11/25/2013. He reported falling backwards from a board, resulting in pain to his back and left leg. The injured worker was diagnosed as having thoracolumbar sprain/strain and L5-S1 foraminal stenosis. Treatment to date has included diagnostics, back support, medications, and physical therapy. Currently (6/05/2015), the injured worker complains of ongoing pain in his lower back. Exam of the lumbar spine noted focal midline tenderness at L2-L5, decreased range of motion, strength 5/5 except right extensor hallucis longus 4+/5 and left 3/5. Sensation was within normal limits in the lower extremities. Deep tendon reflexes for the quadriceps and Achilles were 3 on the right and 4 on the left. Straight leg raise was positive on the right at 80 degrees and left at 70 degrees. It was documented that he was awaiting electromyogram and nerve conduction studies, evaluation by a neurologist, and selective nerve block (left L5-S1). Magnetic resonance imaging of the lumbar spine from 2/17/2015 was submitted. An electrodiagnostic consultation report for the lower extremities (5/14/2015) was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

One left L5-S1 selective nerve root block: 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 Injection Section Page(s): 46.

Decision rationale: Epidural steroid injections are recommended by the MTUS Guidelines when the patient's condition meets certain criteria. The criteria for use of epidural steroid injections include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment. 3) Injections should be performed using fluoroscopy for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed, and a second block is not recommended if there is inadequate response to the first block. 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. 8) No more than 2 ESI injections. In this case on EMG/NCS conducted on 5/14/15 was normal and an MRI did not support the subjective complaint of radiculopathy, therefore, the request for one left L5-S1 selective nerve root block is determined to not be medically necessary.

One Electromyography (EMG)/Nerve conduction study (NCS): Upheld

Claims Administrator 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): EMGs (electromyography); Nerve conduction studies (NCS) (2015).

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 Chapter, Nerve Conduction Studies (NCS) Section.

Decision rationale: Per the MTUS Guidelines, EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The requesting physician does not provide explanation of why EMG would be necessary for this injured worker, who already has identified pathology. The MTUS Guidelines do not specifically address nerve conduction studies of the lower extremities. Per the ODG, nerve conduction studies are not recommended because there is minimal justification of performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, the injured worker had an EMG/NCS was conducted on 5/14/15 and determined to be normal, therefore, the request for one electromyography (EMG)/nerve conduction study (NCS) is determined to not be medically necessary.

One evaluation by a neurologist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305, 306.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 12 Low Back Complaints Page(s): 78, 79, 90, 288, and 296.

Decision rationale: Per the MTUS Guidelines, the clinician acts as the primary case manager. The clinician provides medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously refer to specialists who will support functional recovery as well as provide expert medical recommendations. Referrals may be appropriate if the provider is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. MTUS guidelines state that the primary care or occupational physicians can effectively manage acute and subacute low back problems conservatively in the absence of red flags. Within the first three months of low back symptoms, only patients with evidence of severe spinal disease or severe, debilitating symptoms, and physiologic evidence of specific nerve root compromise, confirmed by appropriate imaging studies, can be expected to benefit from surgery. Physical-examination evidence of severe neurologic compromise that correlates with the medical history and test results may indicate a need for immediate consultation. The examination may further reinforce or reduce suspicions of tumor, infection, fracture, or dislocation. A history of tumor, infection, abdominal aneurysm, or other related serious conditions, together with positive findings on examination, warrants further investigation or referral. A medical history that suggests pathology originating somewhere other than in the lumbosacral area may warrant examination of the knee, hip, abdomen, pelvis or other areas. In this case, there is no documentation in the available documentation of any concern for red-flag conditions, therefore, the request for one evaluation by a neurologist is determined to not be medically necessary.