

Case Number:	CM15-0148308		
Date Assigned:	08/11/2015	Date of Injury:	04/24/2015
Decision Date:	09/18/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	07/30/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 51 year old female who sustained an industrial/work injury on 4-24-15. She reported an initial complaint of pain in the right hip and lumbar spine. The injured worker was diagnosed as having lumbar strain and radiculopathy. Treatment to date includes medication, physical therapy, and diagnostics. MRI results were reported on 6-16-15. Currently, the injured worker complained of lumbar pain that radiated down to the lower extremities with intermittent numbness and tingling sensations, affecting both legs with right side worse than left. Per the primary physician's report (PR-2) on 6-19-15, exam notes upper and lower reflexes symmetrical bilaterally, sensation intact to light touch, normal gait, muscle pain and back pain. Exam on 6-1-15 notes tenderness to palpation bilateral lumbar paraspinals with spasm bilaterally, unable to flex-extend due to pain, positive straight leg raise, and sensation intact. The requested treatments include Epidural steroid injection at right L4, L5 and S1, EMG/NCs of the bilateral lower extremities, Acupuncture 2x4 for the lumbar spine and right hip, MRI of the right hip, Right hip injection under ultrasound 5 cc 1% lidocaine and 40mg Kenalog, and DME (durable medical equipment): Lumbar spine back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural steroid injection at right L4, L5 and S1: 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 Page(s): 46 of 127.

Decision rationale: Regarding the request for epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Within the documentation available for review, there are no current objective and imaging or electrodiagnostic studies corroborating the diagnosis of radiculopathy. In the absence of such documentation, the currently requested epidural steroid injection is not medically necessary.

EMG/NCs of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 177-179.

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, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG/NCV of the lower extremities, Occupational Medicine Practice Guidelines cite that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, there are no physical examination findings supporting a diagnosis of specific nerve compromise. Furthermore, the NCV portion of the study is not supported for patients presumed to have radiculopathy and there is no provision for modification of the current request. In the absence of clarity regarding the above issues, the currently requested EMG/NCV of the lower extremities is not medically necessary.

Acupuncture 2x4 for the lumbar spine and right hip: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as

"either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it is unclear what current concurrent rehabilitative exercises will be used alongside the requested acupuncture. Additionally, the current request for a visit exceeds the 6-visit trial recommended by guidelines. Unfortunately, there is no provision to modify the current request. As such, the currently requested acupuncture is not medically necessary.

MRI of the right hip: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, MRI (Magnetic Resonance Imaging).

Decision rationale: Regarding the request for hip MRI, CA MTUS does not address the issue. ODG cites that indications include osseous, articular or soft-tissue abnormalities; Osteonecrosis; Occult acute and stress fracture; Acute and chronic soft-tissue injuries; and Tumors. Within the documentation available for review, there are no symptoms/findings suggestive of any of the aforementioned conditions, as the provider noted only mild ROM limitation and tenderness. In light of the above issues, the currently requested hip MRI is not medically necessary.

Right hip injection under ultrasound 5 cc 1% lidocaine and 40mg Kenalog: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter, Trochanteric bursitis injections and Ultrasound (Sonography).

Decision rationale: Regarding the request for injection, CA MTUS does not address the issue. ODG cites that trochanteric bursitis injections are recommended. However, they also cite that conventional anatomical guidance by an experienced clinician is generally adequate. Ultrasound guidance for hip injections is not generally necessary, but it may be considered in the following cases: (1) the failure of the initial attempt where the provider is unable to aspirate any fluid; (2) the size of the patient's hip, due to morbid obesity or disease process, that inhibits the ability to inject without ultrasound guidance. Within the documentation available for review, while an injection appears reasonable, there is no clear rationale for ultrasound guidance and, unfortunately, there is no provision for modification of the current request. In

light of the above issues, the currently requested injection is not medically necessary.

DME: Lumbar spine back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Regarding the request for a back brace, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Within the documentation available for review, the patient is beyond the acute stage of injury and there is no documentation of a pending/recent spine surgery, spinal instability, compression fracture, or another clear rationale for a brace in the management of this patient's injury. In the absence of such documentation, the currently requested back brace is not medically necessary.