

Case Number:	CM15-0034328		
Date Assigned:	03/02/2015	Date of Injury:	12/13/2013
Decision Date:	04/13/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	02/24/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 41 year old female who sustained an industrial related injury on 12/13/13 due to a fall. The injured worker had complaints of low back/buttock pain, right shoulder pain, and right hand/wrist pain. The diagnoses included L4-5 and L5-S1 mild degenerative changes, chronic lumbosacral sprain/strain with chronic low back pain, sacrum/coccyx contusion with chronic coccygodynia, right shoulder sprain/strain with residual pain and possible impingement, and right wrist/hand sprain/strain with residual pain and hand paresthesia. Treatment included physical therapy and a L5-S1 interlaminar epidural steroid injection on 4/9/14. The treating physician requested authorization for bilateral coccygeal nerve blocks under fluoroscopic guidance x2, 1 nerve conduction study/electromyogram (NCS/EMG) for the right upper limb, and 1 consultation with orthopedic. On 2/3/15 the requests were modified or non-certified. Regarding the nerve blocks, the utilization review (UR) physician cited the Official Disability Guidelines and noted the need for repeat injections would be based on documentation of a decrease in visual analog scale scores as well as objective functional benefit. Therefore the request was modified to a quantity of 1. Regarding NCS/EMG, the UR physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted there was no documentation provided of subjective complaints such as numbness and tingling or examination findings noting possible positive Tinel's and Phalen's signs. Therefore the request was non-certified. Regarding the consultation, the UR physician cited the MTUS guidelines and noted the injured worker was being recommended for injections into the shoulder and coccyx. Efficacy

with this treatment should be documented prior to consideration for a consultation with an orthopedic surgeon. There for the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Coccygeal Nerve Blocks under Fluoroscopic Guidance x 2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural steroid injections, diagnostic.

Decision rationale: Selective nerve root blocks are also known as epidural transforaminal injection. MTUS states: 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 treating physician has request bilateral injections x 2, however repeat blocks need to be based on objective documented pain and functional improvement. The previous reviewer has modified the request to bilateral coccygeal nerve blocks under fluoroscopic guidance x 1. As such, the request for Bilateral Coccygeal Nerve Blocks under Fluoroscopic Guidance x 2 is not medically necessary.

NCS/EMG Right Upper limb x 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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 (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies." ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The treating physician does not document evidence of radiculopathy, muscle atrophy, and abnormal neurological findings. The treating physician has not met the above ACOEM and ODG criteria for an EMG of the upper extremities. As such the request for NCS/EMG Right Upper limb x 1 is not medically necessary.

Consult with Orthopedic x 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7 Independent Medical Examinations and Consultations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Office Visit.

Decision rationale: ODG states concerning office visits "Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible." ACOEM additionally states concerning low back complaints: "Assessing Red Flags and Indications for Immediate Referral 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." Medical records do not indicate any red flags for immediate referral. The treating physician has requested multiple treatments, the efficacy of those treatments should be evaluated prior to referral. As such, the request for Consult with Orthopedic x 1 is not medically necessary at this time.