

Case Number:	CM15-0047943		
Date Assigned:	03/20/2015	Date of Injury:	01/22/2009
Decision Date:	05/01/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/13/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 female, who sustained an industrial injury on 1/22/2009. She has reported low back pain with lower extremity involvement. The diagnoses have included discogenic lumbar condition with radiculopathy, shoulder impingement, chronic pain syndrome, left hip joint inflammation and element of hernia. She is status post lumbar fusion. Treatment to date has included mediation therapy, trigger point injections and psychological therapy. Currently, the IW complains of low back pain with lower extremity involvement and left shoulder pain. The physical examination from 2/2/15 documented tenderness along the lumbosacral region and AC and rotator cuff. The plan of care included injection of the left hip, injection of the shoulder, Transcutaneous Electrical Nerve Stimulation (TENS), electromyogram of lower extremity, and continuation of medication therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Back Page(s): 303, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM states "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." ODG states in the Low Back Chapter and Neck Chapter, "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." Medical records already indicate clinical obvious radiculopathy. Previous EMG in 2013 showed L4-5 bilateral radiculopathy. The medical records fail to document significant worsening of symptoms requiring a repeat study. As such, the request for EMG/NCV Bilateral Lower Extremities is not medically necessary.

Subacromial Injection - Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Injections.

Decision rationale: MTUS does not specifically detail shoulder steroid injection. ODG states regarding steroid shoulder injection, "Recommended as indicated below, up to three injections. Steroid injections compared to physical therapy seem to have better initial but worse long-term outcomes." ODG additionally details criteria for Steroid injections: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder. Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months. Pain interferes with functional activities (eg, pain with elevation is significantly limiting work). Intended for short-term control of symptoms to resume conservative medical management. Generally performed without fluoroscopic or ultrasound guidance. Only one injection should be scheduled to start, rather than a series of three. A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response. With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option. The number of injections should be limited to three. The medical records fail to demonstrate failure of conservative therapy. The patient has received injections prior with no significant improvement. As such, the request for Subacromial Injection Left Shoulder is not medically necessary.

IF or Muscle Stimulator - Low Back, Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding interferential units, "Not recommended as an isolated intervention" and details the criteria for selection. Pain is ineffectively controlled due to diminished effectiveness of medications. Pain is ineffectively controlled with medications due to side effects. History of substance abuse. Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment. Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)"If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits."The treating physician's progress notes do not indicate that the patient has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. As such, current request for IF or Muscle Stimulator - Low Back, Left Shoulder is not medically necessary.