

Case Number:	CM15-0050730		
Date Assigned:	03/24/2015	Date of Injury:	05/21/2010
Decision Date:	05/19/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/17/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 53-year-old female who sustained an industrial injury on 5/21/10, relative to repetitive work. Records documented conservative treatment to include requests for chiropractic, physical therapy, aquatic therapy and acupuncture with no documentation of treatment provided or treatment response. The 1/7/15 orthopedic initial report cited complaints of neck, low back and bilateral shoulder pain. Cervical spine exam documented moderate loss of range of motion, bilateral trapezius muscle and C6/7 spinous process tenderness, increased pain with cervical compression and decrease pain with distraction. Lumbar spine exam documented moderate loss of range of motion with positive Lasegue's bilaterally for low back pain. Tenderness to palpation was noted over the bilateral multifidus, L5/S1 spinous processes and bilateral longissimus. Shoulder exam documented fairly symmetrical range of motion with mild to moderate loss in all planes, anterior glenoid and greater tuberosity tenderness bilaterally, and positive Neer's and Hawkin's signs. Bilateral wrist exam indicated that Phalen's sign was positive with numbness to the 4th and 5th digits. Handwritten exam notes documented +2 and symmetrical upper and lower extremity reflexes, and left C6, right C7, and bilateral L4 hypoesthesia. She was unable to perform heel/toe walk. There were essentially illegible handwritten notes regarding 11/23/13 MRI scans of the cervical and lumbar spine and both shoulders. The diagnosis included radiculopathy, cervical herniated nucleus pulposus, cervical sprain/strain, lumbar degenerative disc disease, lumbar sprain, lumbar herniated nucleus pulposus, lumbar facet arthropathy, carpal tunnel syndrome, right acromioclavicular joint sprain/r right shoulder sprain, right rotator cuff tear, and right shoulder impingement syndrome.

The treatment plan requested electrodiagnostic testing in the upper and lower extremities to assess for radiculopathy versus neuropathy. The 2/4/15 orthopedic report cited neck pain radiating to the shoulders, low back pain radiating to the lateral thighs, and bilateral shoulder pain. The injured worker reported that her left leg goes out, causing her to fall. Physical exam and diagnosis were essentially unchanged from the initial exam on 1/7/15. The treatment plan documented review of imaging studies. Authorization was requested for electro diagnostic testing in the upper and lower extremities to assess for radiculopathy versus neuropathy, epidural steroid injection at left C4-6 and left L5/S1, bilateral shoulder subacromial injections, and left partial discectomy L5/S1. The 2/25/15 utilization review non-certified the request for partial left L5/S1 discectomy as there was no clinical evidence of radiculopathy or imaging evidence of a lesion that would support the medical necessity of discectomy. The request for electro diagnostic testing in the upper and lower extremities was non-certified as there was no neurologic exam showing equivocal signs that might warrant clarification. The requests for cervical and lumbar epidural steroid injection were non-certified as there was no documentation of pain in a dermatomal distribution corroborated by imaging studies and no medical necessity of shoulder injection documented in the presented documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient electrodiagnostic testing in the upper and lower extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): Chapter 8: 178, 182; Chapter 12: 303, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back $\frac{1}{2}$ Lumbar and Thoracic, Nerve conduction studies (NCS).

Decision rationale: The California MTUS state that EMG (electromyography) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms that last more than 3 to 4 weeks. The Official Disability Guidelines state that nerve conduction studies are not recommended in low back injuries. The California MTUS guidelines state that electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Guideline criteria have been met. This injured worker presents with neck pain radiating to the shoulders and low back pain radiating to the lateral thighs. There is some clinical exam evidence of a neurologic deficit relative to the cervical and lumbar spine. Therefore, this request is medically necessary at this time.

Epidural steroid injection (ESI) of left C6-C7, left L5-S1 and bilateral shoulder subacromial injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213, Chronic Pain Treatment Guidelines Epidural steroid injection (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Steroid injections.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) supports the use of epidural steroid injections as an option for the treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Radiculopathy must be documented by physical exam and corroborated by imaging studies and/or electro diagnostic studies and the patient should have been unresponsive to conservative treatment. Guideline criteria have not been met. The injured worker presented with neck pain radiating to the shoulders and low back pain radiating to the lateral thighs. Sensory deficits were noted in left C6, right C7, and bilateral L4 dermatomal patterns that do not fully correlate with the pain distribution patterns, and there were no focal motor deficits or reflex changes documented. Additionally, imaging information is not available to allow correlation with exam findings. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, the medical necessity of left C6/7 and left L5/S1 cervical epidural steroid injections cannot be established. The California MTUS recommend two or three subacromial cortisone injections over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. The Official Disability Guidelines recommend shoulder steroid injections for diagnoses of adhesive capsulitis, impingement syndrome, or rotator cuff problems. Criteria include pain not adequately controlled by conservative treatments, pain interferes with functional activities, and intended for short term control of symptoms to resume conservative medical management. Guideline criteria have not been met. This injured worker presents with bilateral shoulder pain with positive impingement testing on exam. Imaging information is handwritten and illegible. Functional assessment is not documented. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. In the absence of this information, the medical necessity of subacromial injections cannot be fully established. Therefore, these requests are not medically necessary at this time.

Outpatient partial L5-S1 left disectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back $i\frac{1}{2}$ Lumbar & Thoracic, Disectomy/Laminectomy.

Decision rationale: The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electro physiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair.

The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guideline criteria have not been met. This injured worker presents with low back pain radiating to the lateral thighs. There was clinical exam evidence of difficulty in heel/toe walking and decreased bilateral L4 sensory loss. There was no specific evidence of a focal motor deficit or reflex change, or radicular symptoms with nerve root compression testing. There is a handwritten note regarding an 11/23/13 lumbar spine MRI which is essentially illegible and there is no formal report available in the provided records. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.