

<b>Case Number:</b>	CM14-0080729		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	01/16/2014
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	05/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2014

### 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. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 65-year-old male with a reported date of injury on 01/16/2014. The mechanism of injury was due to a motor vehicle accident. His diagnoses were noted to include cervical sprain/strain with multilevel disc disease with worsening symptoms, chronic low back pain with 1 level disc disease, and chronic shoulder pain with tendinitis. His previous treatments were noted to include physical therapy and medications. The progress note dated 03/27/2014 revealed worsened symptomology and the injured worker had difficulty going to work due to severe pain, and would continue his therapy. The physical examination noted tenderness to the paraspinal muscles in the cervical spine with extension to 35 degrees, flexion was to 40 degrees, right/left rotation was to 70 degrees, and right/left bending was to 30 degrees with a negative Spurling's and Lhermitte's. The right shoulder showed flexion and abduction was to 140 degrees, internal and external rotation were to 70 degrees, adduction and extension were to 30 degrees with negative laxity. The lumbar spine range of motion was noted to be flexion to 80 degrees, extension was to 10 degrees, right/left bending was to 10 degrees, and a negative straight leg raise. The progress note dated 03/27/2014 revealed complaints of pain and stiffness in the neck with spasms. There was pain noted to his shoulder. The physical examination revealed no guarding to the cervical spine or spasm. There was a negative Spurling's and Lhermitte's. The range of motion was noted to be extension to 30 degrees, flexion was to 35 degrees, right/left rotation was to 70 degrees. The dorsal lumbar spine noted tenderness in the paraspinal muscles and a negative straight leg raise and faber. Flexion was noted to be 70 degrees, extension was to 10 degrees, and right/left bending was to 20 degrees. The motor strength was rated 5/5 in the upper and lower extremities. The progress note dated 04/21/2014 revealed complaints of pain to the neck, low back, and shoulder. The injured worker complained of radiating pain to the upper extremities. The physical examination revealed decreased range of

motion. The Request for Authorization form dated 02/11/2014 was for physical therapy 2 times 4 weeks, for pain. The Request for Authorization form for trigger point injections, electromyography and nerve conduction velocities for the bilateral upper and lower extremities, and lumbar spine epidural injection under fluoroscopic guidance at level L4-5 quantity 3 and the provider's rationale was not submitted within the medical records.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cervical Spine Epidural Injection under Fluoroscopic Guidance at level 5-6 Quantity: 3.00:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 45.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

**Decision rationale:** The request for a Cervical Spine Epidural Injection under Fluoroscopic Guidance at level 5-6 Quantity: 3.00 is not medically necessary. The injured worker complained of neck pain that radiated to the upper extremities. The California Chronic Pain Medical Treatment Guidelines recommend epidural steroid injections as an option for the treatment of radicular pain (defined as pain in a dermatomal distribution with corroborated findings of radiculopathy). The guidelines' criteria for the use of epidural steroid injections are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The injured worker must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Injections should be performed using fluoroscopy for guidance. If used for diagnostic purposes, a maximum of 2 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 1 to 2 weeks between injections. No more than 2 nerve root levels should be injected using transforaminal blocks, and no more than 1 interlaminar level should be injected in 1 session. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with an associated reduction in medication use for 6 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. The guidelines recommend no more than 2 epidural steroid injections. There is a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution. The most recent progress note was mostly illegible, and therefore, there are not significant clinical findings to corroborate radiculopathy. The documentation provided indicated an MRI had been performed. However, it does not state what body region or the results. Additionally, the guidelines recommend no more than 2 epidural steroid injections and a series of 3 is not supported by the guidelines. Therefore, the request is not medically necessary.

**Trigger Point Injections Quantity: 6.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

**Decision rationale:** The request for Trigger Point Injections Quantity: 6.00 is not medically necessary. The injured worker complained of radiating back pain. The California Chronic Pain Medical Treatment Guidelines recommend trigger point injections only for myofascial pain syndrome, with limited lasting value. They are not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for nonresolving trigger points, but the addition of a corticosteroid is not generally recommended. The guidelines' criteria for trigger point injection include documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. The symptoms must have persisted for more than 3 months. Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs, muscle relaxants have failed to control pain. Radiculopathy must not be present by examination, imaging, or neuro testing. No more than 3 to 4 injections per session, and no repeat injections unless a greater than 50% pain relief is obtained for 6 weeks after an injection, and there is documented evidence of functional improvement. Frequency should not be at an interval of less than 2 months, and trigger point injections with any substance other than a local anesthetic with or without steroid are not recommended. There is a lack of documentation regarding circumscribed trigger points with a twitch response as well as referred pain, and the guidelines do not recommend more than 3 to 4 injections per session. Therefore, due to lack of documentation regarding circumscribed trigger points, and the request for 6 injections exceeds guideline recommendations, trigger point injections are not appropriate at this time. Therefore, the request is not medically necessary.

**NCS (nerve conduction study) of Right Upper Extremity Quantity: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines, 2nd edition, 2004 Page 303 Electromyography (EMG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Nerve Conduction Studies.

**Decision rationale:** The request for an NCS (nerve conduction study) of Right Upper Extremity Quantity: 1.00 is not medically necessary. The injured worker complained of radiating pain to the upper extremities. The Official Disability Guidelines do not recommend nerve conduction studies to demonstrate radiculopathy if radiculopathy has already been clearly identified by electromyography and obvious clinical signs, but recommended if the electromyography is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or nonneuropathic processes if other diagnoses may be likely based on the clinical

exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. There is a lack of documentation showing significant neurologic deficits such as decreased motor strength or sensation in a specific dermatomal distribution. Therefore, the request is not medically necessary.

**EMG (Electromyography) of Left Upper Extremity Quantity: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines, 2nd edition, 2004 Page 303 Electromyography (EMG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for EMG (Electromyography) of Left Upper Extremity Quantity: 1.00 is not medically necessary. The injured worker complained of radiating pain to the upper extremities. The CA MTUS/ACOEM Guidelines state physiologic evidence may be in the form of definitive neurologic findings upon physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise in the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of a nerve dysfunction can be obtained before ordering an imaging study. Electromyography and nerve conduction velocities, including H reflex test, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The guidelines state electromyography can be used to identify physiologic insult and anatomic defects. There is a lack of documentation regarding significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution. Electromyography can be utilized when radiculopathy is present on the physical examination but the affected nerve is not clear. There is a lack of documentation with significant clinical findings to warrant an electromyography. Therefore, the request is not medically necessary.

**NCS (nerve conduction study) of Left Upper Extremity Quantity: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines, 2nd edition, 2004 Page 303 Electromyography (EMG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Nerve Conduction Studies.

**Decision rationale:** The request for an NCS (nerve conduction study) of Left Upper Extremity Quantity: 1.00 is not medically necessary. The injured worker complained of radiating pain to the upper extremities. The Official Disability Guidelines do not recommend nerve conduction studies to demonstrate radiculopathy if radiculopathy has already been clearly identified by electromyography and obvious clinical signs, but recommended if the electromyography is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or nonneuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. There is a lack of documentation showing significant neurologic deficits such as decreased motor strength or sensation in a specific dermatomal distribution. Therefore, the request is not medically necessary.

**EMG (Electromyography) of Right Lower Extremity Quantity: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines, 2nd edition, 2004 Page 303 Electromyography (EMG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The request for an EMG (Electromyography) of Right Lower Extremity Quantity: 1.00 is not medically necessary. The injured worker complained of radiating pain to the lower extremities. The CA MTUS/ACOEM Guidelines state electromyography, including H reflex test, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. The guidelines recommend electromyography to identify and define disc protrusion, cauda equina syndrome, spinal stenosis, and postlaminectomy syndrome. Electromyography is utilized when radiculopathy is present on the physical examination but the affected nerve is not clear. There is a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution. Therefore, the request is not medically necessary.

**NCS (nerve conduction study) of Right Lower Extremity Quantity: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines, 2nd edition, 2004 Page 303 Electromyography (EMG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Nerve Conduction Studies.

**Decision rationale:** The request for an NCS (nerve conduction study) of Right Lower Extremity Quantity: 1.00 is not medically necessary. The injured worker complained of radiating pain to the lower extremities. The Official Disability Guidelines do not recommend nerve conduction studies. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The systematic review and meta analysis demonstrate that neurologic testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. There is a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution. The guidelines do not recommend nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. There is a lack of documentation regarding previous conservative treatments attempted prior to requesting a nerve conduction study. Therefore the request is not medically necessary.

**EMG (Electromyography) of Left Lower Extremity Quantity: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines, 2nd edition, 2004 Page 303 Electromyography (EMG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The request for an EMG (Electromyography) of Left Lower Extremity Quantity: 1.00 is not medically necessary. The injured worker complained of radiating pain to the lower extremities. The CA MTUS/ACOEM Guidelines state electromyography, including H reflex test, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. The guidelines recommend electromyography to identify and define disc protrusion, cauda equina syndrome, spinal stenosis, and postlaminectomy syndrome. Electromyography is utilized when radiculopathy is present on the physical examination but the affected nerve is not clear. There is a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution. Therefore, the request is not medically necessary.

**NCS (nerve conduction study) of Left Lower Extremity Quantity: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) , Low Back, Nerve Conduction Studies.

**Decision rationale:** The request for an NCS (nerve conduction study) of Left Lower Extremity Quantity: 1.00 is not medically necessary. The injured worker complained of radiating pain to the lower extremities. The Official Disability Guidelines do not recommend nerve conduction studies. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The systematic review and meta analysis demonstrate that neurologic testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. There is a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution. The guidelines do not recommend nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. There is a lack of documentation regarding previous conservative treatments attempted prior to requesting a nerve conduction study. Therefore the request is not medically necessary.

**Lumbar Spine Epidural Injection under Fluoroscopic Guidance at level 4-5 Quantity: 3.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 45.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

**Decision rationale:** The request for a Lumbar Spine Epidural Injection under Fluoroscopic Guidance at level 4-5 Quantity: 3.00 is not medically necessary. The injured worker complained of neck pain that radiated to the upper extremities. The California Chronic Pain Medical Treatment Guidelines recommend epidural steroid injections as an option for the treatment of radicular pain (defined as pain in a dermatomal distribution with corroborated findings of radiculopathy). The guidelines' criteria for the use of epidural steroid injections are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The injured worker must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Injections should be performed using fluoroscopy for guidance. If used for diagnostic purposes, a maximum of 2 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 1 to 2 weeks between injections. No more than 2 nerve root levels should be injected using transforaminal blocks, and no more than 1 interlaminar level should be injected in 1 session. In

the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with an associated reduction in medication use for 6 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. The guidelines recommend no more than 2 epidural steroid injections. There is a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution. The most recent progress note was mostly illegible, and therefore, there are not significant clinical findings to corroborate radiculopathy. The documentation provided indicated an MRI had been performed. However, it does not state what body region or the results. Additionally, the guidelines recommend no more than 2 epidural steroid injections and a series of 3 is not supported by the guidelines. Therefore, the request is not medically necessary.

**Physical Therapy Quantity: 8.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The request for Physical Therapy Quantity: 8.00 is not medically necessary. The injured worker has participated in at least 14 sessions of physical therapy. The California Chronic Pain Medical Treatment Guidelines recommend active therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The guidelines' recommendation for myalgia and myositis is 9 to 10 visits over 8 weeks. There is a lack of documentation regarding quantifiable objective functional improvements with previous physical therapy sessions. There is a lack of exceptional factors regarding additional physical therapy sessions. There is a lack of documentation of symptomatic or functional improvement from previous physical therapy sessions and therefore, the medical necessity for additional therapy has not been established. As such, the request is not medically necessary.

**EMG (Electromyography) of Right Upper Extremity Quantity: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines, 2nd edition, 2004 Page 303 Electromyography (EMG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for EMG (Electromyography) of Right Upper Extremity Quantity: 1.00 is not medically necessary. The injured worker complained of radiating pain to the upper extremities. The CA MTUS/ACOEM Guidelines state physiologic evidence may be in the form of definitive neurologic findings upon physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise in the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of a nerve dysfunction can be obtained before ordering an imaging study. Electromyography and nerve conduction velocities, including H reflex test, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The guidelines state electromyography can be used to identify physiologic insult and anatomic defects. There is a lack of documentation regarding significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution. Electromyography can be utilized when radiculopathy is present on the physical examination but the affected nerve is not clear. There is a lack of documentation with significant clinical findings to warrant an electromyography. Therefore, the request is not medically necessary.