

<b>Case Number:</b>	CM15-0004861		
<b>Date Assigned:</b>	01/16/2015	<b>Date of Injury:</b>	07/24/2013
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2015

### 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: New York  
 Certification(s)/Specialty: Internal 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:

This 68 year old female was injured 7/24/13 from a trip and fall incident resulting in a sharp increase in neck pain with radiation into the back and left groin area. She had been experiencing neck and shoulder pain 18 months into her very demanding job (2009) but could not pin down a date as to when this started. She has a prior history of non-industrial injury to the cervical spine, left shoulder, left upper extremity, low back and left leg. Currently she complains of intermittent neck pain radiating to the trapezius area and left upper extremity with shooting pain into fingers; left shoulder pain, left groin pain. Her medications are Nalfon, Protonix, Tramadol ER, Flexaril, LidoPro cream, Terocin patches, Norco, Ativan and trazadone. Her activities of daily living are compromised and she can perform light duties when pain is decreased. Diagnoses included chronic discogenic neck pain with left cervical radiculopathy; multilevel degenerative disc disease with left foraminal compromise; chronic left hip and groin pain, rule out lumbar disc protrusion L4-5 right; posttraumatic trochanteric bursitis, left hip, rule out degenerative osteoarthritis; chronic pain related to depression, stress and sleep and impingement syndrome left shoulder. Treatments include transcutaneous electrical nerve stimulator unit, hot and cold wrap, exercise ball. Diagnostic studies included MRI of the lumbar spine, MRI left hip (2014) and right hip; multiple radiographs of the lumbar and cervical spine; electromyography left lower extremity. On 12/16/14 the treating provider requested injection of the left hip; MRI of her left shoulder; nerve studies of upper and lower extremities; transcutaneous electrical nerve stimulator unit and brace; Nalfon, Protonix, Tramadol Extended release; Flexaril, Norco; Ativan; Terocin patches and trazadone. LidoPro cream. On 12/18/14 Utilization Review non-certified left hip

injection citing ODG and no functional deficits cited on documentation to support the hip pathology. The pain management consult was non-certified based on MTUS Guidelines. The MRI without contrast Neck Electromyogram/ Nerve Conduction Velocity for bilateral upper extremities was non-certified based on no change in medical condition citing MTUS. The request for electromyogram/ nerve conduction velocity for lower extremities was non-certified based on MTUS guidelines.

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

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

#### **Injection of the Left Hip under Fluoroscopy: 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), Hip and Pelvis, Intra-articular Steroid Injections (IASIII)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation , Intra-articular Steroid hip injury

**Decision rationale:** Per guidelines, hip injections are recommended as an option for short-term pain relief in hip trochanteric bursitis. The treatment is not recommended in early hip osteoarthritis and is under study for moderately advanced or severe hip OA. The injured worker complaints of chronic left hip and groin pain and documentation indicates that previous hip MRI revealed left hip labral tear and tendinosis . Per guidelines, criteria for intra-articular hip injection are not met. The request for left hip injection is not medically necessary.

#### **Consultation with Pain Management: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, Independent Medical Examinations and Consultations

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 80,Chronic Pain Treatment Guidelines Chronic pain programs, functional restoration programs. Chapter 5, Cornerstones of Disability P.

**Decision rationale:** MTUS states that the clinician should judiciously select and refer to specialists who will support functional recovery as well as provide expert medical recommendations. Chronic pain programs are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work. The injured worker is reported to remain disabled from work due to chronic pain and documentation fails to show motivation to return to work. The request for pain management is not medically necessary based on MTUS.

#### **Cervical MRI without Contrast: 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), Neck and Upper Back Chapter, Indications for Imaging, MRI, and Chronic Neck Pain

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 177, Chronic Pain Treatment Guidelines Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations Pag.

**Decision rationale:** MTUS recommends cervical spine MRI in patients with neck pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. Documentation indicates that the injured worker's radicular neck pain is chronic and there are no physical exam findings noted to signify specific nerve compromise. The request for MRI without contrast Neck is not medically necessary.

**Electromyogram / Nerve Conduction Velocity for Bilateral Upper Extremities:** 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), Pain, Electrodiagnostic Testing (EMG/NC)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 177.

**Decision rationale:** Guidelines state that Electromyography (EMG) and nerve conduction velocities (NCV) may be useful to obtain unequivocal evidence of radiculopathy and to identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Documentation indicates that the injured worker complaints of chronic radicular neck pain and is diagnosed with left cervical radiculopathy and multilevel degenerative disc disease. The request for Electromyogram/ Nerve Conduction Velocity for bilateral upper extremities is not medically necessary based on MTUS.

**Electromyogram / Nerve Conduction Velocity for Lower Extremities:** 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), Pain, Electrodiagnostic Testing (EMG/NCS)

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

**Decision rationale:** Guidelines state that Electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks , and to obtain unequivocal evidence of radiculopathy, after 1-month conservative

therapy. MTUS and ODG guidelines state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Documentation indicates that the injured worker complaints of left hip and groin pain, shooting down left leg and previous lumbar spine MRI revealed multi-level degenerative disc disease. Per guidelines, the request for electromyogram/ nerve conduction velocity for lower extremities is not medically necessary.