

<b>Case Number:</b>	CM15-0014758		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	04/26/2013
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	01/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/26/2015

### 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: California  
 Certification(s)/Specialty: Emergency 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 42 year old female, who sustained an industrial injury on April 26, 2013. The diagnoses have included acute cervical strain, multilevel small disc osteophyte complex with mild central canal stenosis at C4-C5 and C5-C6 and mild foraminal narrowing secondary to uncovertebral and facet degeneration on the right at C3-C4 and C4-C5 per MRI dated February 12, 2014, acute thoracic strain with a normal MRI dated February 13, 2014, and acute lumbar strain with 3mm disc bulge at L5-S1 per MRI dated February 12, 2014, as well as small left foraminal disc protrusion with associated annular fissure with minimal narrowing of the anterior aspect of the left neural foramina at L4-L5 per MRI dated February 12, 2014. Treatment to date has included physical therapy and medications. Currently, the injured worker complains of cervical spine, lumbar spine, and bilateral shoulder pain. The Primary Treating Physician's report dated December 18, 2014, noted the examination of the cervical spine revealed tenderness to palpation, with limited range of motion and decreased strength and sensation bilaterally at C5, C6, C7, and C8. The thoracic spine examination noted tenderness to palpation, significantly limited range of motion with flexion, and limited bilateral rotation. Examination of the lumbar spine revealed decreased strength and sensation at L4, L5, and S1. On January 5, 2015, Utilization Review non-certified an EMG/NCS of the bilateral upper extremities and a lumbar epidural steroid injection, based on the available reports and the MTUS guidelines. The MTUS, Chronic Pain Medical Treatment Guidelines, the MTUS American College of Occupational and Environmental Medicine (ACOEM) Guidelines, and the Official Disability Guidelines (ODG)

were cited. On January 26, 2015, the injured worker submitted an application for IMR for review of an EMG/NCS of the bilateral upper extremities and a lumbar epidural steroid injection.

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

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

**EMG/NCS of the bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182 and 272.

**Decision rationale:** EMG and NCV requested by provider are 2 different tests, testing for different pathologies. If one test is not recommended, this requested will be considered not medically necessary as per MTUS independent medical review guidelines. As per ACOEM Guidelines, Nerve Conduction Velocity Studies is not recommended for repeat 'routine' evaluation of patients for nerve entrapment. It is recommended in cases where there is signs of median or ulnar nerve entrapment. There is no documentation of any median nerve entrapment of exam consistent with carpal tunnel syndrome. NCV is not medically necessary. As per ACOEM Guidelines, EMG is not recommended if prior testing, history and exam is consistent with nerve root dysfunction. EMG is recommended if pre procedure or surgery is being considered. Pt has not had any documented changes in neurological exam or complaints. There is exam consistent with potential radiculopathy but findings are chronic. There is no rationale about why testing is requested for a chronic condition except for "chronic condition". EMG is not medically necessary. EMG and NCV of bilateral upper extremities are not medically necessary.

**Lumbar epidural steroid injection:** Upheld

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

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

**Decision rationale:** As per MTUS Chronic Pain Guidelines, Epidural Steroid Injections(ESI) may be useful in radicular pain and may recommended if it meets criteria. 1)Goal of ESI: ESI has no long term benefit. It can decrease pain in short term to allow for increasingly active therapy or to avoid surgery. The documentation fails to provide rationale for LESI. There is no long term plan. Fails criteria.2)Unresponsive to conservative treatment. There is no appropriate documentation of prior conservative therapy attempts. Pt has only undergone 1-2 PT sessions at time of request. There is no noted home exercise program and no other conservative measures include 1st line medications for claimed radicular pain has been attempted. Fails criteria. Patient fails multiple criteria for lumbar epidural steroid injection. Lumbar epidural steroid injection is not medically necessary.

