

Case Number:	CM13-0009333		
Date Assigned:	06/06/2014	Date of Injury:	07/27/2009
Decision Date:	07/11/2014	UR Denial Date:	07/23/2013
Priority:	Standard	Application Received:	08/12/2013

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 Neurologist 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 55-year-old male who reported an injury on 07/29/2009; the mechanism of injury not cited within the documentation provided. The injured worker had diagnoses including cervical myelopathy and cervical stenosis. In the clinical notes dated 04/09/2013, the injured worker complained of bilateral neck pain, bilateral hand pain and bilateral foot pain with aggravating factors of prolonged standing and lifting. It was noted that he was status post fluoroscopically-guided diagnostic bilateral L3-L4 and bilateral L4-L5 facet joint medial branch block on 03/28/2013 which was positive and provided 90% relief of bilateral low back pain after 30 minutes lasting longer than 2 hours. The injured workers prescribed medication regimen included Neurotin 600mg, Zipsor, Pristiq, Voltaren Gel, nortriptyline, and hydrocodone 10/325mg. It was annotated that Amrix was used for prior treatment. The physical examination of the cervical spine revealed restricted and painful range of motion in all directions and positive cervical discogenic maneuvers. The physical examination of the lumbar spine revealed restricted and painful range of motion in all directions with tenderness upon palpation of the lumbar paraspinal muscles overlying the bilateral L3-S1 facet joints. The physical examination of bilateral hands revealed muscle spasms upon palpation. Nerve root tension signs were negative bilaterally and muscle strength was noted as 5/5 bilaterally. The diagnoses included status post positive fluoroscopically-guided diagnostic bilateral L3-L4 and bilateral L4-L5 facet joint medial branch block, disc protrusion at L2-L3 measuring 2mm, disc protrusion at L3-L4 measuring 2 mm with mild bilateral neural foraminal stenosis, mild bilateral neural foraminal stenosis at L4-L5, lumbar degenerative disc disease, lumbar facet joint arthropathy, right sacroiliac joint pain, bilateral carpal tunnel syndrome, bilateral foot pain, bilateral foot internal derangement, mild right ulnar nerve compression, at the wrist, borderline distal ulnar nerve conduction velocities (possibly suggestive of polyneuropathy), fracture at the base of the C1

dens, central disc protrusion at C4-C5, C5-C6, and C6-C7 measuring 3-4mm with severe central stenosis and severe right neural foraminal stenosis, central disc protrusion at C3-C4 measuring 3-4mm, cervical degenerative disc disease, cervical facet joint arthropathy and depression secondary to chronic pain. The treatment plan included a fluoroscopically-guided bilateral L3-L4 and L4-L5 facet joint radiofrequency nerve ablation (neurotomy/rhizotomy) to more permanently treat the injured workers low back pain, continuation of prescribed medication regimen and follow up visit in four weeks to reassess clinical progress. The injured worker's work restrictions included no bending, lifting, twisting, repetitive upper extremity or lower extremity activities, overhead activities and no standing or walking for greater than 10 minutes at a time. There was also no operation of machinery. The request for authorization for somatosensory evoked potentials for the diagnoses of cervical myelopathy and cervical stenosis was submitted on 07/11/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

SOMATOSENSORY EVOKED POTENTIALS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM -<https://www.acoempracguides.org/> Cervical and Thoracic Spine; Table 2, Summary of Recommendations, Cervical and Thoracic Spine Disorders.

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, Evoked potential studies.

Decision rationale: The Official Disability Guidelines (ODG) state that somatosensory evoked potentials (SSEPs) is used for clinical diagnosis in patients with neurologic disease for prognostication in comatose patients. Fewer diagnostic SSEP studies are being performed now than in the pre-MRI era. In the clinical notes provided for review, there is a lack of documentation of evidence or rationale for the request of the somatosensory evoked potentials. The clinical notes annotated that the injured worker had negative nerve root tension signs bilaterally and there were no other neurological or functional deficits. There is also lack of documentation of the injured workers pain level status with or without the use of prescribed medications or prior conservative treatments. Furthermore, the guidelines recommend the use of somatosensory evoked potentials in cases with neurologic disease for prognostication in comatose patients. Therefore, the request for somatosensory evoked potentials is not medically necessary and appropriate.