MAXIMUS Federal Services

Case Number:	CM13-0041751		
Date Assigned:	12/20/2013	Date of Injury:	11/24/2012
Decision Date:	05/02/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/30/2013

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 Occupational Medicine and is licensed to practice in California. 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 applicant has filed a claim for chronic neck and shoulder pain reportedly associated with an industrial injury of November 24, 2012. Thus far, the applicant has been treated with following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; and work restrictions. It does not appear that the applicant is working with restrictions in place, however. In a Utilization Review Report of October 10, 2013, the claims administrator denied a request for electrodiagnostic testing of the upper and lower extremities, a spine surgery consultation, a TENS unit, Naprosyn, Prilosec, and Tramadol. The applicant's attorney subsequently appealed. An earlier note of September 19, 2013 is notable for comments that the applicant reports persistent neck, low back, and shoulder pain. Limited range of motion is noted about multiple body parts. The applicant exhibits tenderness about the cervical and lumbar paraspinal muscles with positive straight leg raising and a positive Spurling maneuver. Reflexes are symmetric. Right shoulder range of motion is painful and limited with positive signs of internal impingement appreciated. The applicant is given diagnoses of severe disk herniations of the cervical spine with bilateral upper extremity radicular pain, lumbar disk herniation with bilateral lower extremity pain and partial rotator cuff tear in left shoulder. It is stated that the applicant has failed epidural injections and physical therapy. A spine surgery consultation, electrodiagnostic testing, a 30-day trial of a TENS unit, and Tramadol are sought. A 20-pound lifting limitation is endorsed, which the attending provider states that the applicant's employer is apparently unable to accommodate. Also reviewed is an MRI of the cervical spine of August 13, 2013, notable for 4-mm broad-based disk bulge at C6-C7 with associated with moderate-to-severe left-sided neuroforaminal narrowing and disk degeneration at C5-C6 with associated mild-to-moderate central canal stenosis and neuroforaminal narrowing. An MRI of the lumbar spine of August 13, 2013 is also notable for 3-mm right paracentral disk bulge

causing associated neuroforaminal narrowing with severe hypertrophic facet degenerative changes. An L5-S1 disk protrusion is also causing lateral recess narrowing with mass effect on the traversing left S1 nerve root.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY (EMG) FOR BILATERAL UPPER EXTREMITIES.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, table 8-8, EMG testing for the diagnosis or suspected diagnosis of nerve root involvement is "not recommended" if findings of history, physical exam, and imaging study are consistent. In this case, the applicant's primary treating provider has diagnosed the applicant with severe disk herniations of the cervical spine. There is evidence of moderate-to-severe neuroforaminal narrowing of the C6-C7 level. Thus, the applicant appears to have radiographic corroboration for ongoing radicular complaints. EMG testing, as noted by ACOEM, is superfluous as the diagnosis of radiculopathy has already been definitively established. Therefore, the request is not certified, on Independent Medical Review.

ELECTROMYOGRAPHY (EMG) FOR BILATERAL LOWER EXTREMITIES.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, table 12-8, EMG testing is "not recommended" for a diagnosis of clinically obvious radiculopathy, as is present here. The applicant has ongoing complaints of low back pain radiating to the legs. The applicant has evidence of neuroforaminal narrowing and mass effect on the left S1 nerve root, which seemingly account for ongoing radicular complaints. Thus, the diagnosis of radiculopathy has already been established, both clinically and radiographically. EMG testing is superfluous, for all of the stated reasons. Therefore, the request is likewise not certified, on Independent Medical Review.

NERVE CONDUCTION STUDIES (NCV) FOR BILATERAL UPPER EXTREMITIES.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: While the MTUS Guideline in ACOEM Chapter 8, page 178 states that EMG and/or NCV testing can be employed to help identify subtle, focal neurologic dysfunction in applicants with neck or arm symptoms which last greater than three to four weeks, in this case, however, the applicant already has a clinically evident, radiographically confirmed diagnosis of cervical radiculopathy at the C6-C7 level. NCV testing to search for another cause of the applicant's symptoms is not indicated. Therefore, the request is likewise not certified, on Independent Medical Review.

NERVE CONDUCTION STUDIES (NCV) FOR BILATERAL LOWER EXTREMITIES.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: The MTUS does not address the topic. However, the Third Edition ACOEM Guidelines on electromyelography note that nerve conduction studies are usually normal in cases of suspected radiculopathy. While nerve conduction studies can be employed to rule out other causes of lower leg symptoms, such as a possible generalized peripheral neuropathy, in this case, the information on file suggests that the applicant already has a clinically evident, radiographically confirmed lumbar radiculopathy. There is no mention of any superimposed disease processes such as diabetes or hypertension which could give rise to generalized peripheral neuropathy which could mimic sciatica. Therefore, the request is likely not certified, on Independent Medical Review, as the applicant already has clinically evident, radiographically confirmed lumbar radiculopathy without evidence of superimposed disease processes which could make the case for nerve conduction testing of the lower extremities.

TENS (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION) UNIT TRIAL FOR 30 DAY RENTAL.: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

Decision rationale: As noted on page 116 of the MTUS Chronic Pain Medical Treatment Guidelines, criteria for the use of TENS include evidence of chronic, intractable pain of greater than three-month duration in applicants in whom other appropriate pain modalities, including

pain medications, have been tried and/or failed. In this case, the information on file suggests that the applicant has chronic pain issues which have proven recalcitrant to other treatments including time, medications, physical therapy, epidural steroid injections, and an oral medication, Naprosyn. A 30-day trial of a TENS unit is therefore indicated to try and combat the applicant's chronic pain issues. Accordingly, the original utilization review decision is overturned. The request is certified, on Independent Medical Review.