

Case Number:	CM14-0007596		
Date Assigned:	02/07/2014	Date of Injury:	12/11/2009
Decision Date:	08/04/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/21/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 patient is 61-year-old male who has submitted a claim for cervical radiculitis, shoulder impingement syndrome, left shoulder adhesive capsulitis, muscle spasm, chronic pain, low back pain, lumbar radiculitis, left axillary neuropathy associated from an industrial injury date of December 11, 2009. Medical records from 2012-2013 were reviewed, the latest of which dated December 6, 2013 revealed that the patient complains of neck pain, bilateral shoulder pain, arm pain, left greater than the right, and low back pain radiating to the bilateral lower extremities. He rates the pain as a 7-10/10. He has been taking opioid analgesics for the pain with no bowel or bladder complaints. He uses a cane for ambulation and is complaining of left leg weakness as well. He had a week of pain reduction and improved function with the last toradol and trigger point injection. On physical examination, the patient ambulates with a straight cane. He has limitation in range of motion with flexion to approximately 30 degrees and extension to approximately 20 degrees. There is spasm across the left paracervical region and positive Spurling's at the left side. There is decreased sensation along the left C6-7 distribution. There is limitation in range of motion of the left shoulder. There is weakness of the left upper extremity with 4/5 strength. Right upper extremity motor testing is 5-/5 with abduction, internal and external rotation. There is limitation in range of motion of the right shoulder. There is tenderness over the sciatic notch and piriformis muscle. MRI of the cervical spine dated July 9, 2010 revealed 1-2mm posterior disc bulges at C4-5, C5-6 and C6-7 without evidence of canal stenosis or neural foraminal narrowing. MRI of the cervical spine dated March 30, 2012 revealed minor changes of cervical discogenic disease and mild to moderate neural foraminal narrowing notably at C5-6. Electrodiagnostic testing of the bilateral upper extremities dated April 12, 2012 revealed left axillary motor neuropathy with evidence of reduced recruitment, large amplitude motor units; right mild to moderate and left mild median neuropathy across the wrists; there is no

evidence of peripheral neuropathy or acute cervical radiculopathy. Treatment to date has included left shoulder manipulation under anesthesia with SLAP debridement (9/18/07), left shoulder manipulation under anesthesia, RCR, open biceps release from bicipital groove and SAD (3/2008), paracervical upper and middle trapezius trigger point injections (10/1/13/, 12/6/13), toradol injections, physical therapy, and medications that include Tylenol, Advil, Vicodin, Nortriptyline, Levitra, Neurontin, Flexeril, Norco, Cymbalta and tramadol. Utilization review from December 30, 2013 denied the request for LEFT C6-7 SELECTIVE NERVE ROOT BLOCK because the EMG was negative for cervical radiculopathy and MRI did not establish nerve root encroachment at the C6-7 level, and denied the request for PAIN PSYCHOLOGIST EVALUATION because the patient was already seen by a pain psychologist in the past for evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left C6-7 selective nerve root block: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46.

Decision rationale: As stated on page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, criteria for epidural steroid injections include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. In this case, the patient still complains of pain after conservative treatment such as injections, physical therapy and medications. However, electrodiagnostic study and MRI results do not support the diagnosis of cervical radiculopathy at the C6-C7 level. The medical necessity for selective nerve root block was not established. Therefore, the request for LEFT C6-7 SELECTIVE NERVE ROOT BLOCK is not medically necessary.

Pain Psychologist Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 391, 398, Chronic Pain Treatment Guidelines Psychological Evaluations.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 - Independent Medical Examinations and Consultations, pages 127, 156.

Decision rationale: As stated on pages 127 & 156 of the ACOEM Guidelines referenced by CA MTUS, consultations are recommended, and a health practitioner may refer to other specialists if

a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. In this case, the patient still complains of pain after surgery and conservative treatment. Records show that a pain psychologist already saw the patient last December 3, 2012 for evaluation; however, the report is not available for review. The result of the previous consult will determine whether another evaluation is medically necessary. Therefore, the request for PAIN PSYCHOLOGIST EVALUATION is not medically necessary.