

Case Number:	CM14-0137662		
Date Assigned:	09/10/2014	Date of Injury:	04/01/2011
Decision Date:	10/07/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	08/26/2014

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 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:

MTUS reference to ACOEM guidelines state there is limited evidence that radiofrequency neurotomy may be effective in relieving or reducing cervical facet joint pain among patient who had a positive response to facet injections. ODG identifies documentation of at least one set of diagnostic medial branch blocks with a response of 70%, no more than two joint levels will be performed at one time (if different regions require neural blockade, these should be performed at intervals of no sooner than one week), and evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy as criteria necessary to support the medical necessity of facet neurotomy. Within the medical information available for review, there is documentation of diagnosis of multi-level cervical degenerative disc disease with hydrosyringomyelia and severe cervical spinal guarding. In addition, given a request of Right sided cervical facet rhizotomy at C6-C7 and C7-T1, there is documentation that no more than two joint levels will be performed at one time. However, there is no documentation of at least one set of diagnostic medial branch blocks with a response of 70% and evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. Therefore, based on guidelines and a review of the evidence, the request for right side cervical facet rhizotomy at C6-C7 and C7-T1, #2 is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANAPROX 550MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical spondylosis with cervical radiculopathy and lumbosacral sprain and strain with lumbar radiculopathy. In addition, there is documentation of pain and ongoing treatment with Anaprox. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Anaprox use to date. Therefore, based on guidelines and a review of the evidence, the request for Anaprox 550mg #120 is not medically necessary.

PRILOSEC 20MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of risk for gastrointestinal events and preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of Omeprazole. Within the medical information available for review, there is documentation of diagnoses of cervical spondylosis with cervical radiculopathy and lumbosacral sprain and strain with lumbar radiculopathy. In addition, there is documentation of ongoing treatment with Prilosec with NSAIDs use. However, despite documentation of ongoing treatment with NSAIDs, there is no documentation of risk for gastrointestinal events (high dose/multiple NSAID). Therefore, based

on guidelines and a review of the evidence, the request for Prilosec 20mg #120 is not medically necessary.

EMG/NCS BILATERAL UPPER EXTREMITIES TO F/O DISC VS PERIPHERAL RADICULOPATHY: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177; 33.

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. Within the medical information available for review, there is documentation of diagnoses of cervical spondylosis with cervical radiculopathy and lumbosacral sprain and strain with lumbar radiculopathy. However, despite documentation of subjective (severe neck pain) and objective (tenderness over the neck, shoulder, and lumbar spine and decreased range of motion) findings, there is no documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for EMG/NCS bilateral upper extremities to r/o disc vs peripheral radiculopathy is not medically necessary.

AME RE-EVALUATION FOR EMG/NCS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PART 1 INTRODUCTION PAGE 1.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177; 33. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. Medical Treatment Guideline identifies documentation that the request represents medical treatment in order to be reviewed for medical necessity, as criteria necessary to support the medical necessity of the requested AME re-evaluation for EMG/NCS. Within the medical information available for review, there is documentation of diagnoses of cervical spondylosis with cervical radiculopathy and lumbosacral sprain and strain with lumbar radiculopathy. However, despite documentation of subjective (severe neck pain) and objective (tenderness over the neck, shoulder, and lumbar spine and decreased range of motion) findings, there is no documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment

that has not responded to conservative treatment. In addition, there is no documentation that the request represents medical treatment that should be reviewed for medical necessity. Therefore, based on guidelines and a review of the evidence, the request for AME re-evaluation for EMG/NCS is not medically necessary.