

Case Number:	CM14-0162127		
Date Assigned:	10/07/2014	Date of Injury:	08/31/1998
Decision Date:	11/26/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/02/2014

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 Family Medicine and is licensed to practice in Ohio. 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 50 year old female with a date of injury of 8-3-2008. Her diagnoses include cervical radiculopathy, brachial neuritis, lumbar facet disease, lumbar radiculopathy, and bilateral shoulder pain. She underwent cervical fusion surgery in 2008 and had a fusion revision with artificial disc placement at C3-C4 and hardware removal 1-17-2012. She continues to have severe neck pain radiating to the upper extremities with numbness and low back pain radiating to the lower extremities. She is being treated with opioids, anti-epileptic drugs, and an antidepressant. The physical exam has revealed diminished cervical range of motion, spasm of the paraspinal cervical musculature and tenderness to palpation of the trapezii and the cervical spine. She has slight hyperesthesia in the bilateral forearms consistent with symptom magnification. Upper extremity reflexes are thought to be normal. An electromyogram done by a rheumatologist on 2-5-2014 was reported as normal. There is a difference of opinion on future course of action: The consulting neurologist feels that more surgery may be necessary and has requested upper and lower electrodiagnostic studies and MRI of the cervical and lumbar spines. The Qualified Medical Examiner feels that no further surgery is necessary and that possibly trigger point injections and/or epidural steroid injections may be necessary, depending on symptoms. Of note, an EMG/NCV of the upper extremities from 7-27-2012 showed evidence of mild, chronic neuropathic changes at the C5-C6 distribution. A CT scan of the cervical spine from 6-28-2012 revealed multi-level foraminal stenosis and mild central canal stenosis at C5-C6 and C6-C7.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of bilateral upper extremities/CT scan cervical: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Computed Tomography, Electromyography, and Nerve Conduction Studies

Decision rationale: The official disability guidelines state that MRI or CT imaging studies are valuable when potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. In this instance, at least one of the consulting physicians feels that more surgery may be an option. MRI imaging may be contraindicated because of the presence of extensive metallic hardware. Therefore, CT imaging of the cervical spine is medically necessary. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50%-71%) and highly specific (65%-85%). EMG findings may not be predictive of surgical outcome in cervical surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve root impingement. This is in stark contrast to the lumbar spine where EMG findings have been shown to be highly correlative with symptoms. In this instance, there is a divergence of opinion regarding the potential existence of a radiculopathy. In fact, there is a recently normal electromyogram (EMG). The neurologic exam has suggested no radiculopathy to one examiner and to another, there has been sensory and motor findings to suggest radiculopathy. Because of the divergence of opinion and the potential for more intervention, for example surgery, injections, etc., the guidelines support EMG and NCV in this case and they are therefore medically necessary.