

Case Number:	CM14-0171229		
Date Assigned:	10/23/2014	Date of Injury:	10/02/2001
Decision Date:	11/21/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/16/2014

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 Physical Medicine & Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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 patient is a 64 year old male with an injury date of 10/02/01. The 06/03/14 progress report by [REDACTED] states that the patient presents with headaches and neck pain rated 7/10 that radiates to the bilateral shoulder and deltoid area left worse than right. The patient also presents with intermittent right knee pain rated 4/10 with associated occasional numbness in the right foot. He also has anxiety and depression secondary to injury. The patient is stated to be temporarily totally disabled on 06/24/14. Examination shows diffuse tenderness and spasms over the trapezius and levator scapula region with positive compression and Spurling maneuvers. He also has weakness in the deltoids bilaterally. The patient's diagnoses include: -Disc protrusion at C3-C\$ with moderate right neuroforaminal stenosis and mild left-neuroforaminal stenosis. -Cervicogenic headaches-Disc protrusion at C7-T1-Neuropathic pain of the bilateral upper extremities-Status post anterior cervical decompression and fusion from C4-C5, C5-C5 and C5-C7 with residual pain-Cervical radiculopathy-Mild bilateral distal ulnar neuropathy affecting sensory components-Mild chronic C3-C4 radiculopathy on the night-Anxiety and depression secondary to industrial injury-Vertebral artery aneurysm, 9 mm in diameter-Cervical stenosis with radiculitis and radiculopathy Medications are listed as Norco, Neurontin, Colace and topical creams. The utilization review being challenged is dated 09/22/14. The rotational regarding EMG/NCV Is that there is no documented progressive weakness, atrophy or neurologic dysfunction nor is the patient a candidate for surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV (Electromyography / Nerve Conduction Velocity) of the 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 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

Decision rationale: The patient presents with headaches and neck pain rated 7/10 radiating into bilateral shoulders and deltoid area along with intermittent right knee pain rated 4/10 with associated occasional numbness in the right foot. The treater requests for 1 EMG/NCV of the upper extremities. ACOEM does allow for nerve conduction studies to confirm the diagnosis of CTS or to differential radiculopathy. On the 09/10/14 treatment plan [REDACTED] the request is to rule out radiculopathy vs. peripheral neuropathy. The 02/06/11 AME report cites prior EMG/NCV studies. On 08/26/09 EMG/NCV of both upper extremities showing irritability of the paraspinal muscles, likely spasm with irritability in the C6 myotomes, compatible with root irritation at the foraminal level. NCVs were normal. The study of 05/11/05 reports borderline mild left C6 radiculopathy and mild left greater than right ulnar neuropathy at the elbows. Possibility of left anterior interosseous nerve syndrome. The 12/05/05 study shows chronic left C& radiculopathy, compression of the left median nerve in the forearm and bilateral ulnar neuropathies at the elbow. In this case, the patient has had prior studies from 2011 and 2005 as noted. It has been 5 years since the last set of EMG/NCV studies but the guidelines do not provide any discussion as to any routine repeat of these studies based on on-going symptoms. This patient suffers from chronic pain without much change in neurologic or clinical presentation. No new injuries are reported and no progression of neurologic findings. There does not appear to be any reason to repeat the studies. Therefore, the EMG/NCV (Electromyography / Nerve Conduction Velocity) of the upper extremities is not medically necessary and appropriate.

Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS 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) Urine drug testing (UDT), Pain (Chronic) chapter

Decision rationale: The patient presents with headaches and neck pain rated 7/10 radiating into bilateral shoulders and deltoid area along with intermittent right knee pain rated 4/10 with associated occasional numbness in the right foot. The treater requests for 1 urine drug screen. MTUS guidelines do not specify the frequency of UDS for risks of opiate users. ODG guidelines, however, recommends once yearly urine screen following initial screening with the first 6 months for management of chronic opiate use in low risk patient. For moderate and high risk, more frequent UDS's are recommended. The reports provided document the patient's long

term opioid use. The patient is currently taking Norco and opioid use (Vicodin) is shown since before 01/07/14. UDS reports provided are from 02/27/14, 05/14/14, 06/07/14, and 09/22/14. Inconsistent results in the 02/27/14 05/14/14 and 09/22/14 reports are not discussed. UDS's are routinely used quite frequently and the treater does not provide risk assessment. Three to four times for UDS's per year may be appropriate for high risk opiate users, but is too frequent for routine monitoring. Four reports have been received over 7 months. Therefore, the request of Urine Drug Screen is not medically necessary and appropriate.