

Case Number:	CM14-0171829		
Date Assigned:	10/23/2014	Date of Injury:	07/20/2005
Decision Date:	11/21/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/17/2014

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 New York. 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:

This injured member apparently had a repetitive use injury documented 7/20/05 for her shoulders, wrists and back. She is reported to be currently at work full time. She notes the origin of the problem were from lifting/carrying files, typing and prolonged sitting. Her current complaints of neck and shoulder pain are made worse by lifting and typing, the back pain by prolonged sitting and standing. The member has undergone surgical release of right carpal tunnel with residual symptoms as well as an MRI of the left wrist for her carpal tunnel symptoms that showed a ganglion cyst. Consideration is being given a left release and drainage of the cyst. The member has undergone bilateral MRI's of the shoulder that revealed moderate tendonosis. MRI of the LS spine has revealed primarily degenerative change, facet hypertrophy and moderate right neural foraminal narrowing at L5-S1. She has recently undergone upper and lower extremity EMG which has been reported as within normal limits. A report 6/12/14 indicates that the member experienced a flare in her symptoms after falling off a stool in August 2013. She reports that her back pain did not respond adequately to approximately 30 treatments each with chiropractic and PT and 2 acupuncture visits. She reports that her neck pain radiates into her hands bilaterally. She reports that her LBP (low back pain) is worse than her leg pain. She describes the leg symptoms as burning and tingling bilaterally. Examination of the back reveals TTP (tender to palpation) of the lumbar spine with +ve facet provocation testing. With +ve SLR (straight leg raise) pain bilaterally R>L. Pain in the shoulders is described as 7/10 bilaterally with popping and grinding noted on use of the arms overhead. Wrist pain is described as 8/10 Left and 9/10 Right. Neck pain is described as 9/10 compared to 7/10 for the LS spine. ROM (range of motion) for the neck is approximately normal for all directions of motion. The member appears to have seen each of the listed members of [REDACTED] for some element of ongoing care. It would appear that [REDACTED] has focused on the shoulders and wrist, [REDACTED]

██████ on EMG evaluation and Pain Management, ██████ on the neck pain and ██████ on the LBP. ██████ has consistently reported his diagnosis as Facetogenic Back Pain and evaluations have indicated that he feels the leg pain is separate from the back pain and not radicular. His intention with the medial facet blocks is in consideration for possible use of Rhizotomy for what he considers failed conservative management with Analgesics (Tramadol/Norco prn), NSAID's (unknown), chiropractic, PT and acupuncture. ██████ believes that the neck pain manifests as radicular symptoms into the arms and that the shoulder MRI's have not been illuminating and the carpal tunnel does not explain the symptoms into the arms. It would appear that the four listed providers have been working collaboratively managing the manifold concerns of this injured worker over an extended period of time in an attempt to maximize her functional capacities and maintain her at work full time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Open MRI of the cervical spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 171,177-178.

Decision rationale: With a suspicion for Nerve Root Compression with Radiculopathy for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. In this situation that criteria appears to have been more than adequately fulfilled with attempts through analgesics, NSAID's and work modification. Criteria for ordering imaging studies include failure to progress in a strengthening program which this patient had been instructed in. There had been confusion as to the source of the neck pain with potentially radicular symptoms in the face of ongoing issues with her wrist and shoulders. If physiologic evidence indicates tissue insult or nerve impairment next steps could include selection of an imaging test such as an MRI to define neural or other soft tissue causes. In this case other evaluations for the wrist and shoulders had not been confirmatory as the source of her neck and arm problems. The C-Spine MRI could clearly demonstrate issues with nerve root compression or definitively eliminate the C-Spine as the culprit. The request is medically necessary.

Medial branch block bilaterally at L4-5: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

Decision rationale: The members LBP (low back pain) had flared after a fall from a stool in 2013. She underwent approximately 30 episodes of PT and chiropractic manipulation as well as ongoing management with analgesics, NSAID's and job modification with no long term improvement. The member reported worse discomfort with prolonged standing or sitting. The member additionally had complaints of burning and tingling in both legs in addition to +ve SLR which would lead one to suspect radicular problems, however this was not confirmed by EMG of the LE or recent MRI that found significant DDD (degenerative disc disease) and facet hypertrophy but only issues associated with a degree of neural foraminal narrowing at Right L5-S1. Believing that the underlying back pain was most likely related to facet issues the proposal was to utilize Medial Branch Block at L4-5. This was as a diagnostic tool to help determine the potential utility of Rhizotomies to assist in maintaining her functional status. Lumbar facet neurotomies reportedly produce mixed results and where they clearly have utility in the cervical spine need to be used selectively in the lumbar area. The member had clearly failed conservative management. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks which this provider was proposing. Under these circumstances the use of the Medial Branch Block should be supported to maintain and enhance this injured workers functional status. The request is medically necessary.

Follow up with provider for general ortho complaints: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 12th Edition, Web, 2014, Office Visits

Decision rationale: The reviewer rightly looked to the ODG since the MTUS is silent on this particular issue. The review of the justification was coherent and the approval for review by a provider was justified. The issue with the denial for the specific provider I believe speaks to the issue of continuity of care that simplifies ongoing assessments and best maintenance of functional stability and recovery. The denial speaks to the selection of the provider as the responsibility of the insurer. This would be quite appropriate for the initial selection. Once care has been rendered and an ongoing relationship established, unless the insurer determines there is some reason to disrupt this relationship, the ability to follow-up for established ongoing care should not be denied. I believe this denial should be overturned. The request is therefore medically necessary.

Pain management consultation with [REDACTED]: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 12th Edition 2014 Web, Office Visits

Decision rationale: The reviewer rightly looked to the ODG since the MTUS is silent on this particular issue. The review of the justification was coherent and the approval for review by a provider was justified. The issue with the denial for the specific provider I believe speaks to the issue of continuity of care that simplifies ongoing assessments and best maintenance of functional stability and recovery. The denial speaks to the selection of the provider as the responsibility of the insurer. This would be quite appropriate for the initial selection. In this case the only documented contact with the patient was in relation to completing an EMG of the upper and lower extremities. It would appear that any of the 3 treating providers, working within the same group, could take responsibility for ongoing pain management. This would especially be true for the provider proposing the Medial Branch Block as a diagnostic test for the potential Rhizotomy for pain control. A much more aggressive approach to pain management than just medications. The initial denial of the selection of a specific pain management specialist is supported. The request is not medically necessary.