

Case Number:	CM14-0025940		
Date Assigned:	06/13/2014	Date of Injury:	03/22/1988
Decision Date:	07/15/2014	UR Denial Date:	02/16/2014
Priority:	Standard	Application Received:	02/28/2014

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 and Rehabilitation, 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:

This a female patient with a date of injury of March 22, 1988. A utilization review determination dated February 16, 2014 recommends non-certification of EMG of bilateral upper extremities, nerve conduction velocity testing of bilateral upper extremities and left L5 and S1 selective nerve root block. A progress note dated February 4, 2014 identifies subjective complaints of returning pain since left L5 and S1 SNRB done on July 29, 2013 which provided 90% improvement of pain and function for six months. The patient reports to be participating in pool therapy and using a treadmill without flare-ups of pain. The patient had a left L5 and A1 SNRB on May 20, 2013 with 60 - 80% improvement of left leg pain until she started biking. The patient responds well to Toradol intramuscularly for pain control. Patient reports right-sided neck pain and is status post a right C6 and C7 SNRB done August 13, 2012 with 70% improvement of pain for over a year. The patient reports worsening paresthesias of the right hand greater than the left. The patient is permanent and stationary with respect to her injury. Patient reports a pain level of 5/10 of the right neck and shoulder. The patient takes Vicodin for pain. Physical examination of the cervical spine identifies flexion of 35, extension 30, right-sided rotation 50, left-sided rotation 60, positive Spurling's sign on the right, 5/5 strength of right elbow and wrist with extension, and the left upper extremity is preserved. Physical examination of the lumbar spine identifies positive straight leg raise of the left side at 60 degrees, decreased sensation in left L5-S1 distribution tenderness over the facet joints and over the left piriformis muscle, tenderness across the lower lumbar region with trigger points identified at the para lumbar region bilaterally, 5/5 strength with dorsiflexion and plantar flexion, 5/5 strength of hips, knees, and ankles. Diagnoses include cervical spondylosis, cervical disc herniation at C5 - 6 and C6 - 7, cervical foraminal stenosis, cervical radiculitis, muscle spasm, thoracic outlet syndrome, lumbar disc herniation, lumbar radiculitis, piriformis syndrome, and thoracic radiculitis. The treatment plan recommends repeat

right C6 and right C7 selective nerve root block under fluoroscopy with sedation, request for a last L5 and S1 selective nerve root block with fluoroscopy and sedation, continuation of home exercise program for upper extremity paresthesias, requests for repeat EMG (Electromyography)/ nerve conduction study of upper extremities, continue Topamax 25 mg one tablet by mouth daily or twice daily for neuropathic pain, and authorization for ongoing monthly visits and trigger point injections. A progress note dated March 4, 2014 has unchanged subjective complaints, physical examination, diagnoses, and treatment recommendations since the visit the previous month.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY (EMG) TESTING OF UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178 and 182. Decision based on Non-MTUS Citation ODG Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies.

Decision rationale: Regarding the request for one EMG (Electromyography) of bilateral upper extremities, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Within the documentation available for review, there are no recent physical examination findings identifying significant neurologic change since the last nerve conduction velocity test, for which a repeat of electrodiagnostic testing would be indicated. In the absence of such documentation, the currently requested EMG (Electromyography) of bilateral upper extremities is not medically necessary.

NERVE CONDUCTION VELOCITY (NCV) TESTING OF UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178 and 182. Decision based on Non-MTUS Citation ODG Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies.

Decision rationale: Regarding the request for one nerve conduction velocity test of bilateral upper extremities, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Within the documentation available for review, there are no recent physical

examination findings identifying significant neurologic change since the last nerve conduction velocity test, for which a repeat of electrodiagnostic testing would be indicated. In the absence of such documentation, the currently requested nerve conduction velocity test of bilateral upper extremities is not medically necessary.

LEFT L5- S1 SELECTIVE NERVE 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 9792.20-9792.26 and 46 of 127 Epidural steroid injections (ESIs) Page(s): 26, 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural steroid injections, diagnostic.

Decision rationale: Regarding the request for injection one left L5, S1 selective nerve root block, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Regarding repeat epidural injections, guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Within the medical information made available for review, there is documentation that a previous L5, S1 selective nerve block done July 29, 2013 provided the patient with up to 90% pain relief for 6 months. However, there are no current, clear complaints of pain in the lower back or of the left leg along the L5 or S1 dermatomal distribution. In the absence of clarity within the documentation, the requested left L5, S1 selective nerve root block is not medically necessary.