MAXIMUS Federal Services

Case Number:	CM14-0028697		
Date Assigned:	06/16/2014	Date of Injury:	08/04/2003
Decision Date:	07/17/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/06/2014

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 Arizona. 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:

Patient is a 47 year old female with a date of injury on 8/4/2003. Diagnoses include intervertebral disc disorder with myelopathy, status post right rotator cuff repair, and cervicobrachial syndrome. Subjective complaints are of right shoulder pain and burning sensation down right arm, with an increasing level of pain. Physical exam shows cervical spine decreased range of motion, and paravertebral spasm and tenderness on the right. Spurling's maneuver caused pain and radiation. Upper extremity reflexes were reduced. Right shoulder range of motion was reduced, and right elbow had tenderness and positive Tinel's sign. Motor strength was 4/5 on the right. Sensation was decreased in the C5-C7 dermatomes. Cervical spine MRI from 8/22/13 shows mild central canal stenosis from C4-5 and C6-7 from bulging discs. On 7/2/2013 patient had a left neck medial branch block which decreased her pain by more than 75%, and cervical radiofrequency ablation at C3-C5 on 9/11/13. Pain improved 70% for 3 weeks status post procedure. Prior EMG in 2008 noted left C8-T1 radiculopathy, and 2012 EMG was normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (ELECTROMYOGRAPHY) OF THE BILATERAL UPPER EXTREMITIES:
Overturned

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): 179, 182 213, 261, 269.

Decision rationale: ACOEM guidelines suggest EMG as a means of detecting physiologic insult in the upper back and neck. EMG/NCS can also be used to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection, but is not recommended for diagnosis if history, physical, and previous studies are consistent with nerve root involvement. For shoulder complaints ACOEM does not recommend EMG/NCV for evaluation for usual diagnoses. For hand/wrist complaints EMG/NCV is recommended as appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. For this patient, subjective and objective signs/symptoms show evidence of nerve root involvement versus ulnar neuropathy at the elbow. Electrodiagnostic testing could help confirm the etiology of the ongoing symptoms. Therefore, the request for upper extremity EMG is medically necessary.

NCS (NERVE CONDUCTION STUDY) OF THE BILATERAL UPPER EXTREMITIES: Overturned

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): 179, 182 213, 261, 269.

Decision rationale: ACOEM guidelines suggest EMG as a means of detecting physiologic insult in the upper back and neck. EMG/NCS can also be used to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection, but is not recommended for diagnosis if history, physical, and previous studies are consistent with nerve root involvement. For shoulder complaints ACOEM does not recommend EMG/NCV for evaluation for usual diagnoses. For hand/wrist complaints EMG/NCV is recommended as appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. For this patient, subjective and objective signs/symptoms show evidence of nerve root involvement versus ulnar neuropathy at the elbow. Electrodiagnostic testing could help confirm the etiology of the ongoing symptoms. Therefore, the request for upper extremity NCS is medically necessary.

CERVICAL MEDIAL BRANCH BLOCK-C3, C4, C5 ON THE RIGHT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: CA MTUS suggests that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. The ODG states that facet joint medial branch blocks are only recommended as a diagnostic tool for consideration of the facet joint as a pain source. The ODG states that diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Treatment requires a diagnosis of facet joint pain. Criteria for diagnostic blocks include: One set of diagnostic medial branch blocks is required with a response of 70%. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks, and no more than 2 joint levels are injected in one session. For this patient, submitted documentation indicates pain that is radicular and not consistent with the diagnosis of facet joint pain. Therefore, the medical necessity of a medial branch block is not established.