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| Case Number: | CM14-0072254 | | |
| Date Assigned: | 08/08/2014 | Date of Injury: | 10/09/2010 |
| Decision Date: | 09/15/2014 | UR Denial Date: | 05/07/2014 |
| Priority: | Standard | Application Received: | 05/19/2014 |

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 59 year old male who reported an injury to his neck and upper back. The utilization review dated 08/20/14 resulted in denials for computerized testing, electrodiagnostic studies, interferential unit, and MRI of the cervical spine and medications. A clinical note dated 04/19/13 indicated the injured worker complaining of upper extremities and neck pain. The injured worker was identified as having low back and mid back pain rated 8/10. Upon exam, strength was 4+/5 in the left upper extremity with minimal strength deficits in the right. The injured worker was previously approved for epidural steroid injection at C3-4. The injured worker utilized Norco and Tramadol for pain relief. Electrodiagnostic studies on 05/07/14 revealed mildly abnormal findings at the carpal tunnel on the right. A clinical note dated 05/07/14 indicated the injured worker continued with complaints of neck pain and low back pain. Numbness and tingling were identified in hands and legs. Injured worker complained of neck pain radiated into the upper extremities with neck extension. The injured worker demonstrated strength deficits in the upper extremities. Reflex deficits were identified at the brachioradialis bilaterally. Reflex deficits were identified strength at as hyperreflexia was identified at the right patella.

IMR ISSUES, DECISIONS AND RATIONALES

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

Computerized Range of Motion testing: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) IIME and Consultations, Page 503.

Decision rationale: The request for computerized range of motion testing was not medically necessary. The injured worker complained of neck pain and low back pain. It is unclear what computerized range of motion testing is necessary when typically during an office evaluation range of motion deficits would be identified. Therefore, this request is not medically necessary.

EMG Right 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 12 Low Back Complaints Page(s): 303.

Decision rationale: The injured worker recently underwent electrodiagnostic studies of the upper extremities. The injured worker was confirmed with right sided carpal tunnel syndrome. Therefore, there does not appear to be any development of significant changes in the symptomology. Additionally, no information was submitted confirming any changes in pathology. Given this, the request for EMG of the Right Upper Extremities is not medically necessary.

NCV Right Upper Extremities: 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) Low Back Chapter, Nerve conduction studies (NCS).

Decision rationale: The injured worker recently underwent electrodiagnostic studies of the upper extremities. The injured worker was confirmed with right sided carpal tunnel syndrome. Therefore, there does not appear to be any development of significant changes in the symptomology. Additionally, no information was submitted confirming any changes in pathology. Given this, the request for NCV of the Right Upper Extremities is not medically necessary.

Pain Management referral for CESI x 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: The request for three epidural steroid injections in the cervical spine is not medically necessary. Epidural steroid injection is indicated for injured workers with significant neurocompressive findings confirmed by imaging studies and clinical evaluation indicates the injured worker having significant radiculopathy. Additionally, response to initial injection would need to be documented prior to the approval of additional injections. No information was submitted regarding neurocompressive findings additionally no information was submitted regarding specific levels of intended injections. Given this, the request for Pain Management Referral for CESI x3 is not medically necessary.

Home IF Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

Decision rationale: A home IF unit would be indicated following a one month trial. No information was submitted regarding previous trial. Given this, the request for an IF unit is not medically necessary.

MRI - Cervical Spine: Upheld

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): 177-178.

Decision rationale: The request for magnetic resonance image (MRI) of the cervical spine is not medically necessary. The injured worker recently underwent MRI of the cervical spine. No significant information was submitted regarding any changes in pathology or symptomology. Therefore, the request for an MRI of the Cervical Spine is not medically necessary.

Medications: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 77.

Decision rationale: The injured worker is currently utilizing Norco and Tramadol for pain relief. However, no information was submitted regarding response to these medications manifested by pain reduction or functional improvement and therefore the request for Medications is not medically necessary.