

Case Number:	CM15-0131967		
Date Assigned:	07/20/2015	Date of Injury:	04/29/2001
Decision Date:	08/17/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 46 year old female who sustained an industrial injury on 4/29/01 from a slip and fall resulting in back, neck and left shoulder pain. She was diagnosed with cervical sprain; fracture at L5 and was treated with ice and Vicodin. She is currently experiencing increasing neck pain with headaches; she has significant stenosis of the neck; difficulty moving shoulders; upper back pain radiating into both arms and hands; low back pain radiating into both legs and feet with numbness in the left foot and bilateral great toe. On physical exam there was decreased sensation to the right C6 with positive Spurling's test to the right, decreased range of motion. Medications were Norco, Effexor, gabapentin, Voltaren, Soma, zolpidem, alprazolam. Diagnoses include post left knee anterior cruciate ligament repair (1990); post arthroscopic Bankart's procedure, left shoulder (2/7/05); chronic cervical strain with degenerative disc disease at C5,6,7; severe L4-5 and L5-S1 degenerative disc disease with lumbar instability; post posteriolateral interbody fusion at L4-5 and L5-S1 with interbody cage placement; revision post spinal instrumentation (9/24/12). Treatments to date include epidural steroid injection at C5-C6 with significant relief of pain; bone stimulator; medications. Diagnostics include computed tomography of the lumbar spine showing some bone going across the disc space as well as the facet joint (11/21/14); cervical spine x-rays (5/28/15) showing significant arthritis changes at multiple levels worse at C5-6 with foraminal narrowing. In the progress note dated 5/28/15 the treating provider's plan of care included requests for computed tomography scan of the cervical spine with 3 dimensional reconstruction as the injured workers pain is high up in the neck and is not relieved by the computed tomography

epidural injection; electromyography/nerve conduction study of the upper extremities to rule out nerve injury and damage; pain management since Norco is not enough to keep the pain under control.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (electromyography)/ NCS (nerve conduction study), Bilateral Upper Extremities, as it relates to radiculopathy from Cervical Spine: 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 12 Low Back Complaints Page(s): American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004). Chapter 12, page 303.

Decision rationale: This claimant was injured 14 years ago from a slip and fall and had a cervical sprain and a fracture at L5. She has increasing neck pain with headaches. There was decreased sensation to the right C6 with a positive Spurling's test to the right. Diagnoses include a pre-injury left knee anterior cruciate ligament repair (1990); post arthroscopic Bankart's procedure, left shoulder (2/7/05); chronic cervical strain with degenerative disc disease at C5,6,7; severe L4-5 and L5-S1 degenerative disc disease with lumbar instability; post posterolateral interbody fusion at L4-5 and L5-S1 with interbody cage placement; and revision post spinal instrumentation (9/24/12). Past diagnostics include computed tomography of the lumbar spine showing some bone going across the disc space as well as the facet joint (11/21/14). As of May 2015, the pain is high up in the neck and is not relieved by the epidural injection. No neurologic exam with definitive or equivocal neurologic findings of the upper extremities is noted. The request is for electrodiagnostic studies, however. The MTUS ACOEM notes that electrodiagnostic studies may be used when the neurologic examination is unclear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. In this case, there was not a neurologic exam showing even equivocal signs that might warrant clarification with electrodiagnostic testing. The request was appropriately not medically necessary.

CT (computed tomography) Scan with 3D reconstruction: 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 ODG, Neck and Upper Back, CT.

Decision rationale: As shared, this claimant was injured 14 years ago from a slip and fall with cervical sprain and a fracture at L5. She continues with increasing neck pain with headaches. There was decreased sensation to the right C6 with positive Spurling's test to the right. Diagnoses include post left knee anterior cruciate ligament repair (1990); post arthroscopic

Bankart's procedure, left shoulder (2/7/05); chronic cervical strain with degenerative disc disease at C5,6,7; severe L4-5 and L5-S1 degenerative disc disease with lumbar instability; post posterolateral interbody fusion at L4-5 and L5-S1 with interbody cage placement; revision post spinal instrumentation (9/24/12). Past diagnostics include previous computed tomography of the lumbar spine showing some bone going across the disc space as well as the facet joint (11/21/14). As of May 2015, the pain is high up in the neck and is not relieved by the epidural injection. No neurologic exam with definitive or equivocal neurologic findings of the upper extremities is noted. The request is for imaging of the neck. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG cite the following regarding CT imaging of the cervical spine: Suspected cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet; Suspected cervical spine trauma, unconscious; Suspected cervical spine trauma, impaired sensorium (including alcohol and/or drugs); Known cervical spine trauma: severe pain, normal plain films, no neurological deficit; Known cervical spine trauma: equivocal or positive plain films, no neurological deficit; Known cervical spine trauma: equivocal or positive plain films with neurological deficit. In this case, there is subjective neck pain and headaches only. There is no known bony trauma to the neck, just a sprain only, nor is there documentation of normal or equivocal current plain films. Further, no neurologic deficits are noted. Finally, there is no clarification as to why three dimensional imaging is required. The request is appropriately not medically necessary.

Pain Management Consultation and Treatment, within MPN (medical provider network):
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines: Chapter 7 page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, Page 127.

Decision rationale: As shared, this claimant was injured 14 years ago from a slip and fall with cervical sprain and a fracture at L5. Diagnoses include post left knee anterior cruciate ligament repair (1990); post arthroscopic Bankart's procedure, left shoulder (2/7/05); chronic cervical strain with degenerative disc disease at C5,6,7; severe L4-5 and L5-S1 degenerative disc disease with lumbar instability; post posterolateral interbody fusion at L4-5 and L5-S1 with interbody cage placement; revision post spinal instrumentation (9/24/12). Past diagnostics include computed tomography of the lumbar spine showing some bone going across the disc space as well as the facet joint (11/21/14). As of May 2015, the pain is high up in the neck and is not relieved by the epidural injection. No neurologic exam with definitive or equivocal neurologic findings of the upper extremities is noted. This is a request for pain management consult. Per the California MTUS, specifically the ACOEM guidelines Chapter 5, other health-care professionals who treat work-related injuries can make an important contribution to the appropriate management of symptoms. ACOEM Guidelines, Chapter 7 states that a referral request should specify the concerns to be addressed in the independent or expert assessment,

including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinees fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. This request for the pain management consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, the request is not medically necessary.