

Case Number:	CM15-0141311		
Date Assigned:	07/31/2015	Date of Injury:	11/11/1992
Decision Date:	09/02/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/21/2015

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, New York, 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 applicant is a represented 66-year-old who has filed a claim for chronic neck pain reportedly associated with an industrial injury of motor vehicle accident (MVA) of November 11, 1992. In a Utilization Review Report dated July 2, 2015, the claims administrator failed to approve a request for a pain management consultation, electrodiagnostic testing of the left upper extremity, and multilevel cervical medial branch blocks. The claims administrator referenced a May 20, 2015 progress note and an associated RFA form of June 2, 2015 in its determination. Non-MTUS ODG Guidelines were invoked to deny the pain management consultation, despite the fact that the MTUS addressed the topic. The claims administrator contended that the applicant had an established diagnosis of cervical radiculopathy status post earlier spine surgery and also contended that the applicant had recent MRI imaging with abnormal findings. The applicant's attorney subsequently appealed. On said May 20, 2015 progress note, the applicant reported gradually worsening complaints of neck pain with tingling about the left upper extremity. Overall commentary was sparse. The applicant exhibited a normal gait, it was reported. Electrodiagnostic testing of the left upper extremity was sought to rule out radiculopathy versus neuropathy. The applicant's past medical history was not detailed. The applicant was already retired. Medial branch blocks were also sought. It was stated that the applicant had responded fairly to previous treatment. Cervical MRI imaging dated May 4, 2015 was notable for postoperative changes at C3-C7 with multilevel bilateral moderately severe neuroforaminal and spinal stenoses. In an orthopedic surgery note dated April 22, 2015, the applicant was described as having ongoing complaints of neck pain with paresthesias about the bilateral upper extremities, left greater than right. The applicant denied any frank upper extremity weakness. 5/5 upper extremity motor function was appreciated about the bilateral upper and bilateral lower

extremities. Sensorium was intact, it was acknowledged about the upper and lower extremities. The applicant was placed off work. MRI imaging of the cervical spine was ordered. The applicant was asked to consider cervical epidural steroid injection at a following visit. The attending provider stated that the applicant did not have a significant past medical history aside from the industrial injury, a surgery for a constricted esophagus, a cervical spine surgery in 2005, and a hemorrhoidectomy in 2002. The attending provider then stated that the applicant carried diagnoses of cervical radiculopathy and degenerative joint disease of the cervical spine, neuropathy, and erectile dysfunction. It was not clearly stated how the diagnosis of neuropathy had been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consultation with a pain management specialist (spondylosis): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Office visits.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 1: Introduction Page(s): 1.

Decision rationale: Yes, the request for a pain management consultation was medically necessary, medically appropriate, and indicated here. As noted on page 1 of the MTUS Chronic Pain Medical Treatment Guidelines, the presence of persistent complaints, which prove recalcitrant to conservative management, should lead the primary treating provider (PTP) to reconsider the operating diagnosis and determine whether a specialist evaluation is necessary. Here, the applicant was off work. The applicant had longstanding pain complaints, which had proven recalcitrant to various operative and nonoperative interventions. Obtaining the added expertise of a pain management specialist to formulate other treatment options was, thus, indicated. Therefore, the request was medically necessary.

EMG/NCV of left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178; 182.

Decision rationale: Conversely, the request for electrodiagnostic testing of the left upper extremity was not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 8, page 178 does acknowledge that EMG and/or NCV testing may help to identify subtle, focal neurologic dysfunction in applicants with neck or arm symptoms or both which last greater than three to four weeks, this recommendation is, however, qualified by commentary made in the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182 to the effect that EMG testing for a diagnosis of nerve root involvement is "not recommended" if findings of history, physical exam and imaging study are consistent. Here, the applicant had an established diagnosis of cervical radiculopathy status post earlier cervical spine surgery in 2005. Cervical MRI imaging of May 4, 2015 was notable for multilevel bilateral moderate to severe neuroforaminal stenosis and spinal stenoses. Thus, the applicant did, in fact,

carry a diagnosis of clinically evident, radiographically confirmed cervical radiculopathy, effectively obviating the need for the electrodiagnostic testing in question. While the attending provider suggested in a progress note of April 22, 2015 that the applicant might carry superimposed diagnosis of neuropathy, this was neither expounded nor elaborated upon. There was no mention of the applicant is having a systemic disease process such as diabetes, hypothyroidism, alcoholism, hepatitis, etc., which would have heightened the applicant's predisposition toward development of a generalized peripheral neuropathy, for instance. The attending provider stated on April 22, 2015 that the applicant's paresthesias were confined to the C8 dermatome. Thus, all evidence on file pointed to the applicant's having an already well-established diagnosis of cervical radiculopathy, radiographically confirmed, effectively obviating the need for the electrodiagnostic testing at issue. Therefore, the request is not medically necessary.

C4, 5, 6, 7 Medial Branch Block: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Occupational Disorders of the Neck and Upper Back, Facet joint diagnostic blocks.

Decision rationale: Finally, the request for multilevel medial branch blocks was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 181, diagnostic blocks such as the medial branch blocks at issue are deemed "not recommended." Here, it was further noted that all of the documentation submitted, including progress notes of April 22, 2015 and May 20, 2015 suggested that the applicant had an established diagnosis of cervical radiculopathy status post earlier cervical spine surgery. One of the applicant's treating providers wrote on April 22, 2015 that the applicant was considering epidural steroid injection therapy at that point in time. The request, thus, is not indicated both owing to (a) the unfavorable ACOEM position on the article at issue and (b) the superimposed radicular pain complaints which shed doubt on the applicant's carrying a bona fide diagnosis of facetogenic low back pain for which the diagnostic medial branch blocks at issue could have been considered. ODG's Neck and Upper Back Chapter Facet Joint Diagnostic Blocks Topic notes that diagnostic facet blocks (AKA medial branch blocks) should be reserved for applicants with cervical pain, which is nonradicular. Here, the applicant's pain complaints were, in fact, radicular. The attending provider also seemingly targeted three different levels to blockade. ODG's Neck and Upper Back Chapter Facet Joint Diagnostic Blocks Topic stipulates that diagnostic facet blocks target no more than two levels bilaterally. Therefore, the request was not medically necessary.