Case Number:	CM15-0145945		
Date Assigned:	08/07/2015	**Date of Injury:**	03/07/2001
Decision Date:	09/21/2015	**UR Denial Date:**	07/22/2015
Priority:	Standard	**Application Received:**	07/28/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 3-7-2001. The details regarding the initial injury were not clearly documented in the medical records submitted for this review. Diagnoses include cervical radiculopathy, thoracic disc herniation with spinal cord abutment, advanced lumbar facet arthropathy, disc deterioration and factures, lumbar foraminal stenosis, radiculopathy, bowel and bladder dysfunction, and hearing and vision disturbances. status post multiple cervical fusion and revision surgeries and status post lumbar fusion. Treatments to date include activity modification, medication therapy, physical therapy, H-wave therapy, trigger point injections, occipital nerve blocks and epidural steroid injections. Currently, she complained of neck pain with muscle spasms, increasing mid back pain, and ongoing low back pain with numbness and tingling to lower extremities. On 6-19-15, the physical examination documented cervical tenderness with multiple trigger points present. The thoracic spine demonstrated decreased range of motion, tenderness with muscle spasms. The lumbar spine demonstrated decreased range of motion, tenderness, muscle spasms, and positive straight leg raise tests bilaterally. The plan of care included electromyogram and nerve conduction studies (EMG/NCS) of bilateral upper extremities, cervical MRI, trigger point injections to paracervical and thoracic musculatures, and left occipital nerve root block injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram (EMG) and nerve conduction study (NCS) of the upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back (acute and chronic) Chapter under EMG.

Decision rationale: This patient presents with chronic neck and back pain. The current request is for an Electromyogram (EMG) and nerve conduction study (NCS) of the upper extremities. The RFA is dated 07/16/15. Treatments to date include activity modification, medication therapy, physical therapy, H-wave therapy, left shoulder surgery (2003), c-spine fusion (2008, 2014), l-spine fusion (2006), bilateral CTR (2011), trigger point injections, occipital nerve blocks and epidural steroid injections. The patient is not working. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." ODG Guidelines, Neck and upper back (acute and chronic) Chapter under EMG states "recommended as an option in select cases. ODG further states regarding EDS in carpal tunnel syndrome, recommended in patients with clinical signs of CTS and may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), with the additional electromyography (EMG) is not generally necessary." Per report 6-19-15, the patient complained of neck pain with muscle spasms, increasing mid back pain, and ongoing low back pain with numbness and tingling to lower extremities. Physical examination documented cervical tenderness with multiple trigger points present. The thoracic spine demonstrated decreased range of motion, tenderness with muscle spasms. The lumbar spine demonstrated decreased range of motion, tenderness, muscle spasms, and positive straight leg raise tests bilaterally. The patient has had an EMG/NCV of the upper extremity on 07/06/12, which revealed cervical radiculitis with C5-6 nerve roots affected bilaterally. CT Cervical Spine (5/22/15) revealed extensive multilevel postoperative changes reflect prior anterior cervical discectomy/prosthetic interbody fusions at C4 through C7, ventral plate hardware fixations at C3 through C7 and dorsal pedicle screw/hardware fixation at C3-4; residual 3-4 mm RIGHT greater than LEFT posterolateral osteophyte ridging at C6-7 results in mild RIGHT greater than LEFT sided foraminal narrowing at this level; and normal lordosis curvature is exhibited. Reported cervical spine MRI (7/9/12) revealed mild to moderate LEFT facet hypertrophy at C2-3; a 4 mm broad disc osteophyte complex at C3-4 with mild spinal canal stenosis with a conspicuous anterior marginal osteophyte-, 3 mm broad disc osteophyte complex at C4-5 with mild spinal canal stenosis, mild RIGHT facet arthropathy, bilateral small uncovertebral joint osteophytes, and mild RIGHT neural foraminal narrowing; a 4 mm broad based disc osteophyte complex at CS-6 with mild to moderate spinal canal stenosis and disc level fusion; a 5 mm board disc osteophyte complex at C6-7 eccentric to the RIGHT in a paracentral location with moderate to severe RIGHT and moderate LEFT spinal canal stenosis and disc level fusion; report not available for review. The treater is requesting an EMG/NCV of the upper extremities to differentiate between a centralized cervical spine radiculopathy vs. a right ulnar neuropathy given that her symptomology that follows both of the nerve lines. This patient has had a CT scan, EMG/NCV of the upper extremities and MRI of the C-spine. In this case, there is no

documentation of progressive neurological changes affecting the upper extremities to warrant a repeat EMG. The requested EMG/NCV IS NOT medically necessary.

Cervical flexion and extension magnetic resonance imaging (MRI): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Minnesota Rules - Parameters for Medical Imaging.

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

Decision rationale: This patient presents with chronic neck and back pain. The current request is for a Cervical flexion and extension magnetic resonance imaging (MRI). The RFA is dated 07/16/15. Treatments to date include activity modification, medication therapy, physical therapy, H-wave therapy, left shoulder surgery (2003), c-spine fusion (2008, 2014), l-spine fusion (2006), bilateral CTR (2011), trigger point injections, occipital nerve blocks and epidural steroid injections. The patient is not working. ACOEM Guidelines chapter 8, page 177 and 178, state "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." ODG-TWC Neck and Upper Back section, under MRI states "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation)." ODG guidelines Lumbar-spine chapter under flexion/extension studies: "Not recommended as a primary criteria for range of motion. An inclinometer is the preferred device for obtaining accurate, reproducible measurements. See Range of motion (ROM); Flexibility. For spinal instability, may be criteria prior to fusion, for example in evaluating symptomatic spondylolisthesis when there is consideration for surgery." In this case, this patient has had a CT scan, MRI and EMG/NCV of the upper extremities. There is no reported significant change in symptoms or findings that would warrant a repeat MRI. The request is not in accordance with MTUS/ACOEM guidelines for special studies, and does not meet the ODG guidelines for repeat MRI. There is lack of support flexion/extension radiographic studies except for spinal instability. There is no specific discussion regarding flexion/extension MRI's. The request for Repeat cervical MRI IS NOT medically necessary.

Series of trigger point injections to the paracervical and thoracic musculatures: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger-point injections Page(s): 122.

Decision rationale: This patient presents with Chronic neck and back pain. The current request is for a Series of trigger point injections to the paracervical and thoracic musculatures. The RFA is dated 07/16/15. Treatments to date include activity modification, medication therapy, physical therapy, H-wave therapy, left shoulder surgery (2003), c-spine fusion (2008, 2014), l-spine fusion (2006), bilateral CTR (2011), trigger point injections, occipital nerve blocks and epidural steroid injections. The patient is not working. The MTUS Guidelines page 122 under its chronic

pain section has the following regarding trigger-point injections, "Recommended only for myofascial pain syndrome and limited lasting value, not recommended for radicular pain." MTUS further states that all criteria need to be met including documentation of trigger points (circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain), symptoms persistent for more than 3 months, medical management therapy, radiculopathy is not present, no repeat injections unless a greater than 50% relief is obtained for 6 weeks, etc. Per report 6-19-15, the patient complained of neck pain with muscle spasms, increasing mid back pain, and ongoing low back pain with numbness and tingling to lower extremities. Physical examination documented cervical tenderness with multiple trigger points present. The thoracic spine demonstrated decreased range of motion, tenderness with muscle spasms. The lumbar spine demonstrated decreased range of motion, tenderness, muscle spasms, and positive straight leg raise tests bilaterally. The treater recommends a series of Trigger point injections. Although trigger points are found on examination, there is no documentation of twitch response as well as referred pain, as required by MTUS for TPIs. The requested injections ARE NOT medically necessary.

Left occipital nerve root block injections: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head Chapter; ODG, Neck Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back chapter, under Therapeutic Greater Occipital Nerve Block.

Decision rationale: This patient presents with chronic neck and back pain. The current request is for a Left occipital nerve root block injections. The RFA is dated 07/16/15. Treatments to date include activity modification, medication therapy, physical therapy, H-wave therapy, left shoulder surgery (2003), c-spine fusion (2008, 2014), l-spine fusion (2006), bilateral CTR (2011), trigger point injections, occipital nerve blocks and epidural steroid injections. The patient is not working. ODG Neck and Upper back chapter, under Therapeutic Greater Occipital Nerve Block states: "Under study for treatment of occipital neuralgia and cervicogenic headaches. There is little evidence that the block provides sustained relief, and if employed, is best used with concomitant therapy modulations. Current reports of success are limited to small, non-controlled case series. Although short-term improvement has been noted in 50-90% of patients, many studies only report immediate post injection results with no follow-up period. In addition, there is no gold-standard methodology for injection delivery, nor has the timing or frequency of delivery of injections been researched. Limited duration of effect of local anesthetics appears to be one factor that limits treatment and there is little research as to the effect of the addition of corticosteroid to the injectate." Per report 6-19-15, the patient complained of neck pain with muscle spasms, increasing mid back pain, and ongoing low back pain with numbness and tingling to lower extremities. Physical examination documented cervical tenderness with multiple trigger points present. The thoracic spine demonstrated decreased range of motion, tenderness with muscle spasms. The lumbar spine demonstrated decreased range of motion, tenderness, muscle spasms, and positive straight leg raise tests bilaterally. The treater recommends a left occipital nerve root block. In this case, such treatments are still under study and not yet supported as a standard therapy. There is lack of firm guideline support for such injections as a therapeutic measure, and the lack of discussion as to whether this injection is being used as a diagnostic tool, the medical necessity cannot be substantiated. Therefore, the request IS NOT medically necessary.