

Case Number:	CM15-0030726		
Date Assigned:	02/24/2015	Date of Injury:	05/16/2002
Decision Date:	04/03/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/18/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 60 year old male who sustained cumulative industrial injuries to his neck and hands. The injured worker was diagnosed with chronic cervical pain, cervicogenic headaches, bilateral upper extremity radiculopathy and failed back syndrome. The injured worker underwent cervical foraminotomy and fusion to the cervical spine (2004 and 2010), a cervical tumor resection in March 2011, circumferential anterior-posterior extension of the fusion to C2-C6 in October 2012, carpal tunnel release on September 18, 2013, 3 steroid injections to the right long finger flexor tendon sheath, 2 steroid injections into the left long finger tendon sheath and 1 injection to the left thumb. The injured worker also complains of headaches, ringing in the ears bilaterally, dysphagia, laryngitis and bilateral hemi-facial spasms. On October 9, 2014 the injured worker underwent Botulinum Toxin Type-A Neurolysis and cortisone injections to twenty bilateral muscle groups of the face and head. The injured worker has a history of hypertension. According to the primary treating physician's progress report on December 17, 2014 the patient continues to experience chronic neck and bilateral upper extremity radiculopathy and headaches. A brain magnetic resonance imaging (MRI) on August 13, 2014 was negative for acute pathology. There was limited extension and rotation of the neck on examination. Current medications are listed as OxyContin, Oxycodone, Suboxone and Clonidine. Treatment modalities consist of physical therapy, massage, acupuncture therapy and medication. The treating physician requested authorization for a Carotid Duplex Scan. On February 4, 2015 the Utilization Review denied certification for a Carotid Duplex Scan. On Citations were noted by the Utilization Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Caroid Duplex Scan: 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

<http://www.ucdmc.ucdavis.edu/vascular/lab/exams/carotid.html>.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the peer-reviewed evidence-based guidelines (attached link), carotid duplex scan is not medically necessary. A cerebrovascular study in the Vascular Laboratory may be requested to evaluate neurologic symptoms that might be due to vascular disease (such as one-sided loss of strength or sensation, difficulty speaking or transient loss of vision in one eye), a bruit in the neck (a sound heard with a stethoscope), or for other indications. Carotid artery duplex scanning is also used for post-procedure evaluation after surgery, such as carotid endarterectomy or carotid artery stenting. Thorough history taking is always important in the clinical assessment and treatment planning for the patient with chronic pain and includes a review of medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination serves to establish reassurance and patient confidence. Diagnostic studies should be ordered in this context and not simply for screening purposes. In this case, the injured worker's working diagnoses are laryngo-pharyngeal reflux; symptoms involving head and neck-voice disturbance and resonance disorder; chronic laryngitis and laryngotracheitis; tinnitus; and dysphagia. The original work injury appears to be posterior multilevel cervical foramina of any surgery. The injured worker presented with a history of chronic neck pains and bilateral upper extremity radiculopathy. The documentation indicates the injured worker had ringing in his right ear since his surgery/neck fusion one -year prior. The injured worker was referred to an ENT for evaluation of tinnitus and bruxism. There is no documentation of syncope or loss of consciousness. There are no subjective complaints objective clinical findings (carotid bruit or thrill) as an indication for carotid duplex. There is no clinical rationale in the medical record. Consequently, absent clinical documentation with a clinical indication and rationale based on prevailing symptoms and signs, carotid duplex scan is not medically necessary.