MAXIMUS Federal Services

Case Number:	CM15-0038511		
Date Assigned:	03/09/2015	Date of Injury:	06/15/2012
Decision Date:	04/24/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/02/2015

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 54-year-old male, who sustained an industrial injury on June 15, 2012. He has reported injury of the arms, legs, neck, low back, and wrists following an assault by a co-worker. The diagnoses have included assault blunt head trauma, abdomen injury, post traumatic syrinx C2-3, and insomnia. Treatment to date has included medications, and imaging. Currently, the IW complains of continued pain in the arms, legs, neck, back, and wrists. He has reported headaches, and difficulty sleeping. He indicates he has had difficulty with activities of daily living since the injury occurred. Physical findings revealed are a noted depressed mood and affect, tenderness in the neck area with muscle spasms in the trapezii, paravertebral, interscapular, and sternocleidomastoid muscles. He has a decreased range of motion of the neck and lumbar spine areas. The lumbar spine is noted to have tenderness, and pain with range of motion. He has a fatigue severity scale score of 41, and an Epwork sleepiness scale score of 17. The records indicate on January 9, 2015, a cervical spine magnetic resonance imaging reveals disc protusions, and a C2-3 syrinx. The provider indicates the request for electrodiagnostic studies of the arms and legs, is to "differentiate between radiculopathy, peripheral neuropathy, and upper motor neuron causes". On February 20, 2015, Utilization Review non-certified one polysomnogram study, and electromyogram and nerve conduction studies of the bilateral upper extremities, and electromyograpm and nerve conduction studies of the bilateral lower extremities. The Chronic Pain Medical Treatment and ODG guidelines were cited. On February 23, 2015, the injured worker submitted an application for IMR for review of one polysomnogram study, and electromyogram and nerve conduction studies of the bilateral upper extremities, and electromyograpm and nerve conduction studies of the bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Polysomnogram Study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain (chronic), Criteria for Polysomnography.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines chapter 'Pain (chronic)' and topic 'Polysomnography'.

Decision rationale: The patient presents with neck pain radiating to upper extremities and low back pain radiating to lower extremities. The request is for POLYSOMNOGRAM STUDY. The request for authorization is dated 02/11/15. MRI of the cervical spine, 01/09/15, shows at C6-C7 a 3-4mm disc bulge, which mildly flattens the theca and mild bilateral foraminal stenosis. MRI of the thoracic spine, 01/09/15, shows minor discogenic disease and facet hypertrophy, there is no cord compression, significant canal stenosis or significant foraminal stenosis, there is mild right-sided foraminal narrowing at T1-2 and T2-3. The patient complains of headaches in both temples and at the base of his head. The patient complains of difficulty sleeping. The patient complains of depression, worriment and anxiousness. Epworth Sleepiness Scale performed on 11/12/14 was 17 (score above 10 is abnormal). Fatigue severity Scale performed on 11/12/14 was 41 (score above 36 is abnormal). Patient's medications include Naproxen, Hydrocodone, Omeprazole, Norvac, Benazepril, Paroxetine and Hydrochlorothiazide. The patient is not working. ODG-TWC guidelines, chapter 'Pain (chronic)' and topic 'Polysomnography', list the following criteria for Polysomnography: Recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for chronic insomnia, or insomnia associated with psychiatric disorders." For criteria, excessive daytime somnolence; cataplexy; morning headache; intellectual deterioration; personality change not due to meds or psyche problems; sleep-related breathing disorder or periodic limb movement disorder is suspect are required. Per progress report dated, 01/30/15, treater's reason for the request is "to rule out Obstructive Sleep Apnea (OSA)." In this case, treater has documented the patient's complaint of headaches and patient's Epworth Sleep Scale score of 17. However, there is no documentation of excessive daytime somnolence; cataplexy; morning headaches; intellectual deterioration; personality change that would indicate the patient meets guideline criteria. Furthermore, the patient has significant depression and psychiatric etiology for the patient's sleep difficulties have not been ruled out.
Therefore, the request IS NOT medically necessary.

1 EMG/NCS of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines, Low-Back-Lumbar and Thoracic (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

Decision rationale: The patient presents with neck pain radiating to upper extremities and low back pain radiating to lower extremities. The request is for EMG/NCS OF BILATERAL UPPER EXTREMITIES. The request for authorization is dated 02/11/15. MRI of the cervical spine, 01/09/15, shows at C6-C7 a 3-4mm disc bulge, which mildly flattens the theca and mild bilateral foraminal stenosis. MRI of the thoracic spine, 01/09/15, shows minor discogenic disease and facet hypertrophy, there is no cord compression, significant canal stenosis or significant foraminal stenosis, there is mild right-sided foraminal narrowing at T1-2 and T2-3. The patient complains of headaches in both temples and at the base of his head. The patient complains of difficulty sleeping. The patient complains of depression, worriment and anxiousness. Epworth Sleepiness Scale performed on 11/12/14 was 17 (score above 10 is abnormal). Fatigue severity Scale performed on 11/12/14 was 41 (score above 36 is abnormal). Patient's medications include Naproxen, Hydrocodone, Omeprazole, Norvac, Benazepril, Paroxetine and Hydrochlorothiazide. 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." Per progress report dated, 01/30/15, treater's reason for the request is "to differentiate between radiculopathy, peripheral neuropathy, and motor neuron causes." The patient suffers from neck and upper extremity pain. However, per UR letter dated, 02/20/15, "According to submitted documentation, the patient had an EMG/NCV of the bilateral upper extremities on 09/10/13, which showed signs of mild carpal tunnel syndrome." Treater does not provide explanation as to why a repeat study is needed. In addition, there has not been any change in the patient's clinical presentation. Therefore, the request IS NOT medically necessary.

1 EMG/NCS of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines, Low-Back-Lumbar and Thoracic (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'EMGs (electromyography) chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS)'.

Decision rationale: The patient presents with neck pain radiating to upper extremities and low back pain radiating to lower extremities. The request is for EMG/NCS OF BILATERAL LOWER EXTREMITIES. The request for authorization is dated 02/11/15. MRI of the cervical spine, 01/09/15, shows at C6-C7 a 3-4mm disc bulge, which mildly flattens the theca and mild bilateral foraminal stenosis. MRI of the thoracic spine, 01/09/15, shows minor discogenic disease and facet hypertrophy, there is no cord compression, significant canal stenosis or significant foraminal stenosis, there is mild right-sided foraminal narrowing at T1-2 and T2-3. The patient complains of headaches in both temples and at the base of his head. The patient complains of difficulty sleeping. The patient complains of depression, worriment and anxiousness. Epworth Sleepiness Scale performed on 11/12/14 was 17 (score above 10 is abnormal). Fatigue severity Scale performed on 11/12/14 was 41 (score above 36 is abnormal). Patient's medications include Naproxen, Hydrocodone, Omeprazole, Norvac, Benazepril, Paroxetine and Hydrochlorothiazide. The patient is not working. ODG Guidelines, chapter 'Low

Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'EMGs (electromyography)', state that EMG studies are "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS)', states that NCV studies are "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy." Per progress report dated, 01/30/15, treater's reason for the request is "to differentiate between radiculopathy, peripheral neuropathy, and motor neuron causes." The patient suffers from low back and lower extremity pain. Physical examination reveals moderate tenderness in the lumbar spinous processes and paraspinal muscles. However, there is no indication of numbness, tingling or loss of sensation. Patrick, Lasegue's, Babinski tests and straight leg raising were all negative. Furthermore, per UR letter dated, 02/20/15, "According to submitted documentation, the patient had an EMG/NCV of the bilateral lower extremities on 09/10/13, which did not reveal any significant findings." Therefore, the request IS NOT medically necessary.