

Case Number:	CM15-0054706		
Date Assigned:	03/30/2015	Date of Injury:	08/10/2007
Decision Date:	07/09/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	03/23/2015

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 60 year old male patient who sustained an industrial injury on 08/10/2007. A primary treating office visit dated 09/15/2014 reported a chief complaint of work related injury. The patient had subjective complaint of back pain that is rated 2-3 in intensity out of 10 and that current medication regimen offers about 50% relief of symptom. He denies any new issues or change. Current medications consist of: Gabapentin, Tizanidine, Citalopram, omeprazole, Vitamin B12, and Trazadone. He is diagnosed with lumbago, status post surgeries. The patient is found allergic to Lyrica. Objective findings showed the cervical spine noted surgical scar; normal lordotic curvature, and range of motion is within functional limits. The following diagnoses are applied: cervicgia; left shoulder; brachial/cervical neuritis, left; carpal tunnel syndrome, status post release; lateral epicondylitis; sprain elbow/forearm, and myalgia and myositis. The plan of care involved: continuing with current medications; trigger point injections with flare-up; continuing with home exercise program, and follow up in three months. By 12/11/2014 there was a noted change in the treatment plan that is recommending authorization for trigger point injections, treatment for myofascial pain, and follow up visit. A more recent follow up visit dated 01/22/2015 reported continued subjective complaint of neck and upper back pains. There is no change in the medication regimen. He is to return to modified work duty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional capacity evaluation (FCE): 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), Fitness for Duty Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines, Chapter 7, p137-139 has the following regarding functional capacity evaluations Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, under Functional capacity evaluation (FCE).

Decision rationale: The patient presents on 01/22/15 with neck and upper back pain rated 6/10. The patient's date of injury is 08/10/07. The patient's date of injury is 08/10/07. Patient is status post unspecified cervical spine surgeries at dates not provided, and status post carpal tunnel release of an unspecified side. The request is for functional capacity evaluation. The RFA was not provided. Physical examination dated 01/22/15 reveals limited range of motion in the left shoulder with tenderness to palpation of the subacromial area and bicipital tendon area, and tenderness to palpation of the left elbow epicondyle with trigger point noted on the left wrist extensor muscle. Cervical spine examination reveals a healed surgical scar, minimal tenderness to palpation of the cervical paraspinal muscles, trigger points in the left upper trapezius and levator scapulae. Neurological examination reveals slightly decreased motor strength in the bilateral upper extremities and otherwise intact sensation. The patient is currently prescribed Gabapentin, Tizanidine, Citalopram, Omeprazole, Vitamin B12, Levocetirizine, and Trazodone. Diagnostic imaging was not included. Per 01/22/15 progress note, patient is advised to return to work with restrictions ASAP, or remain temporarily totally disabled if work accommodations cannot be made. Regarding functional capacity evaluation, ACOEM Guidelines Chapter page 137 states, "The examiner is responsible for determining whether the impairment results in functional limitations." The employer or claim administrator may request functional ability evaluations. "There is no significant evidence to confirm that FCEs predict an individual's actual capacity to perform in a workplace." ODG Fitness For Duty, Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, under Functional capacity evaluation (FCE) states: "Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally." In regard to the request for a functional capacity evaluation, this patient does not meet guideline criteria for such an evaluation. ACOEM and ODG do not support functional capacity evaluations solely to predict an individual's work capacity, unless the information obtained is crucial or requested by the adjuster/employer. The treating physician's assessment of the patient's limitations are as good as what can be obtained via an FCE. Therefore, the request is not medically necessary.

EMG/NCV of the bilateral upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 - 179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262, 177-178.

Decision rationale: The patient presents on 01/22/15 with neck and upper back pain rated 6/10. The patient's date of injury is 08/10/07. Patient is status post unspecified cervical spine surgeries at dates not provided, and status post carpal tunnel release of an unspecified side. The request is for EMG/NCV of the bilateral upper extremities. The RFA was not provided. Physical examination dated 01/22/15 reveals limited range of motion in the left shoulder with tenderness to palpation of the subacromial area and bicipital tendon area, and tenderness to palpation of the left elbow epicondyle with trigger point noted on the left wrist extensor muscle. Cervical spine examination reveals a healed surgical scar, minimal tenderness to palpation of the cervical paraspinal muscles, trigger points in the left upper trapezius and levator scapulae. Neurological examination reveals slightly decreased motor strength in the bilateral upper extremities and otherwise intact sensation. The patient is currently prescribed Gabapentin, Tizanidine, Citalopram, Omeprazole, Vitamin B12, Levocetirizine, and Trazodone. Diagnostic imaging was not included. Per 01/22/15 progress note, patient is advised to return to work with restrictions ASAP, or remain temporarily totally disabled if work accommodations cannot be made. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations, page 178 states: "Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, Forearm, Wrist, and Hand Complaints, 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." In regard to the EMG/NCV to the upper extremities, the patient does not meet guideline criteria. There is no documentation that this patient has had an EMG/NCV to date. This patient presents with neck pain, but there is no indication that there is pain which radiates to the upper extremities or any other neurological deficits to the upper extremities. The only positive physical findings in the upper extremities are slightly (4/5) decreased strength bilaterally and the presence of a trigger point in the left wrist extensor muscle. NCV/EMG are generally utilized to differentiate between cervical radiculopathy and carpal tunnel syndrome. This patient is status post carpal tunnel release, but does not presently exhibit symptoms suggestive of carpal tunnel syndrome or cervical radiculopathy. Based on the provided documentation, the request is not in accordance with MTUS/ACOEM guidelines and cannot be substantiated. The request is not medically necessary.

Flexion and extension plain films of cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 - 179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The patient presents on 01/22/15 with neck and upper back pain rated 6/10. The patient's date of injury is 08/10/07. The patient's date of injury is 08/10/07. Patient is status post unspecified cervical spine surgeries at dates not provided, and status post carpal tunnel release of an unspecified side. The request is for flexion and extension plain films of cervical spine. The RFA was not provided. Physical examination dated 01/22/15 reveals limited range of motion in the left shoulder with tenderness to palpation of the subacromial area and bicipital tendon area, and tenderness to palpation of the left elbow epicondyle with trigger point noted on the left wrist extensor muscle. Cervical spine examination reveals a healed surgical scar, minimal tenderness to palpation of the cervical paraspinal muscles, trigger points in the left upper trapezius and levator scapulae. Neurological examination reveals slightly decreased motor strength in the bilateral upper extremities and otherwise intact sensation. The patient is currently prescribed Gabapentin, Tizanidine, Citalopram, Omeprazole, Vitamin B12, Levocetirizine, and Trazodone. Diagnostic imaging was not included. Per 01/22/15 progress note, patient is advised to return to work with restrictions ASAP, or remain temporarily totally disabled if work accommodations cannot be made. ACOEM guidelines on special studies for C-spine Chapter 8 (p177, 178) states: "X-rays: Initial studies may be warranted only when potentially serious underlying conditions are suspected like fracture or neurologic deficit, cancer, infection or tumor. (Bigos, 1999) (Colorado, 2001) - Emergence of a red flag- Physiologic evidence of tissue insult or neurologic dysfunction- Failure to progress in a strengthening program intended to avoid surgery- Clarification of the anatomy prior to an invasive procedure." MTUS/ACOEM chapter 8, table 8-7 on page 179, states: Cervical radiographs are most appropriate for patients with acute trauma associated with midline vertebral tenderness, head injury, drug or alcohol intoxication, or neurologic compromise. In regard to the request for flexion/extension radiography of the cervical spine, the patient does not meet guideline criteria. ACOEM supports cervical radiography in the presence of red-flag symptoms, if there is evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program, or clarification of anatomy prior to a procedure. In this case, the patient does not possess any red-flag symptoms, has no evidence of recent injury or tissue insult, exhibits no symptoms of neurologic dysfunction in the upper extremities, and is not pending any procedures. There is no evidence of spondylolisthesis or recent injury with suspicion for segmental instability to warrant a set of flex/ext X-rays. Progress note dated 01/22/15 states that the reason for the requested imaging is to better assess this patient's impairment rating, though the use of imaging for this purpose is not supported by guidelines and cannot be substantiated. Therefore, the request is not medically necessary.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 - 179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official disability

guidelines 'Neck and Upper Back (Acute & Chronic)' and topic 'Magnetic resonance imaging (MRI).

Decision rationale: The patient presents on 01/22/15 with neck and upper back pain rated 6/10. The patient's date of injury is 08/10/07. The patient's date of injury is 08/10/07. Patient is status post unspecified cervical spine surgeries at dates not provided, and status post carpal tunnel release of an unspecified side. The request is for MRI of the cervical spine. The RFA was not provided. Physical examination dated 01/22/15 reveals limited range of motion in the left shoulder with tenderness to palpation of the subacromial area and bicipital tendon area, and tenderness to palpation of the left elbow epicondyle with trigger point noted on the left wrist extensor muscle. Cervical spine examination reveals a healed surgical scar, minimal tenderness to palpation of the cervical paraspinal muscles, trigger points in the left upper trapezius and levator scapulae. Neurological examination reveals slightly decreased motor strength in the bilateral upper extremities and otherwise intact sensation. The patient is currently prescribed Gabapentin, Tizanidine, Citalopram, Omeprazole, Vitamin B12, Levocetirizine, and Trazodone. Diagnostic imaging was not included. Per 01/22/15 progress note, patient is advised to return to work with restrictions ASAP, or remain temporarily totally disabled if work accommodations cannot be made. 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 Guidelines, chapter 'Neck and Upper Back (Acute & Chronic)' and topic 'Magnetic resonance imaging (MRI)', have the following criteria for cervical MRI: (1) Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present (2) Neck pain with radiculopathy if severe or progressive neurologic deficit (3) Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present (4) Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present (5) Chronic neck pain, radiographs show bone or disc margin destruction (6) Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal" (7) Known cervical spine trauma: equivocal or positive plain films with neurological deficit (8) Upper back/thoracic spine trauma with neurological deficit. ODG guidelines also state that "repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." In regard to the request for what appears to be this patient's first MRI of the cervical spine, the patient does not meet guideline criteria. ACOEM supports such imaging in cases where neck pain fails to resolve after 3 months of conservative treatment in the presence of neurologic signs or symptoms, or in cases where there is suspicion of cervical trauma. This patient presents with neck pain but otherwise normal neurological function in the upper extremities and no red-flag symptoms. Progress note dated 01/22/15 states that the reason for the requested imaging is to better assess this patient's impairment rating, though the use of MRI imaging for this purpose is not supported by guidelines and cannot be substantiated. Therefore, the request is not medically necessary.