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| Case Number: | CM14-0184527 | | |
| Date Assigned: | 11/12/2014 | Date of Injury: | 10/19/2012 |
| Decision Date: | 12/18/2014 | UR Denial Date: | 10/24/2014 |
| Priority: | Standard | Application Received: | 11/05/2014 |

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a case of a 26 year old female with a date of injury of 10/19/2012. In a QME report by [REDACTED] dated 7/22/2013 it reports that the patient was working as an assistant manager for [REDACTED] in [REDACTED] and was helping a teller with a transaction. As she turned around, her heel caught the teller's heel causing her to fall forward. She hit the right side of her face and head against a retaining wall and fell to the floor. She lost consciousness for several minutes and she was carried to the back room by her coworkers. Paramedics were not called and her father picked her up and drove her home. The event took place on a Friday and she returned to work on Monday, but left early. She was seen at a worker's compensation clinic where she was evaluated by a [REDACTED] on 10/24/2012. She had an exam and was prescribed medications. She had x-rays of her head and neck and also prescribed physical therapy. She complained of headaches, primarily on the right side of the head, occasional global headaches. She has pain on the right side of her neck radiating from the paracervical regions to the right upper back area. She also has perceived memory loss. She notes tingling in her arms radiating to the right shoulder and dorsum of the forearm and hand with occasional tingling pain to her lower back. She describes headaches as constant, right sided neck pain as frequent and tingling as occasional. The intensity of pain in her neck is 6-8/10, average of 4-5. Headaches are 2-6/10, average 4-5. She was diagnosed with head trauma/concussion and brief loss of consciousness, post-concussion syndrome, chronic cervical/upper trapezius strain/sprain, and residual right upper extremity radicular symptomatology. MRI of the cervical spine done 4/28/2014 revealed left C4-5 neuroforaminal narrowing from a prominent uncovertebral spur, mild-moderate spondylosis at C4-5 level and mild spondylosis at C5-6 and less at C6-7. MRI of the brain without contrast also done on 4/28/2014 was normal. In a neurosurgical visit note dated 9/4/2014 by [REDACTED], the

patient's chief complaint was low back pain/neck pain. She reports having neck pain, headaches, and bilateral tingling of her hands and feet. She denies any radicular symptoms. She was placed on Naprosyn without benefit. She reports some weakness in her right upper extremity. She also reports base of neck spasms and pain radiating to the base of her head with frequent headaches. On physical examination, she has 4/5 right wrist flexion, biceps and triceps. 5/5 other muscle groups in the upper and lower extremities. She also has 2+ patellar reflex, and 2+ biceps reflex. She notes tingling in her distal fingers tips bilaterally and distal feet bilaterally. She was diagnosed with Lumbago, Cervicalgia, and rule out peripheral neuropathy/radiculopathy. Bilateral EMGs were requested and the patient was started on Neurontin 100mg 3 times a day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical ESI with sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: Based on MTUS guidelines, epidural steroid injections (ESIs) are recommended as an option for the treatment of radicular pain. Most current guidelines recommend no more than 2 ESIs. ESIs can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that ESIs may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of ESIs to treat radicular cervical pain. Criteria for the use of ESIs are: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. 2) Initially unresponsive to conservative treatment. 3) Injections should be performed using fluoroscopy for guidance. 4) If used for diagnostic purposes, a maximum of 2 injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than 2 nerve root levels should be injected using transformational blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6-8 weeks, with a general recommendation of no more than 4 blocks per region per year. 8) Current research does not support a "series of three" injection in either the diagnostic or the therapeutic phase. We recommend no more than 2 ESIs. In this case, the patient denies any radicular symptoms noted in a report by [REDACTED] dated 9/4/2014. Also, based on MTUS guidelines there are insufficient evidence to make any recommendation for the use of ESI's to treat radicular cervical pain. Lastly, the MRI report dated 4/28/2014 does not seem to correlate with C5-6 radiculopathy on

physical examination. Instead, there was noted that there was a left C4-5 neuroforaminal narrowing from a prominent uncoverterbral spur. Lastly, the request did not specify what vertebral area of the cervical region would be given the ESI. Therefore, based on the evidence in this case and the review of the MTUS guidelines, the request for Cervical ESI with sedation is not medically necessary.

Medical clearance (EKG, chest X-ray, labs, CBC, SMP, VA, PT, PTT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section 9792.20 Page(s): 46.

Decision rationale: In general, medical clearance is not recommended prior to ESI. In this specific case since the request for Cervical ESI sedation was found not to be medically necessary, then also Medical Clearance (EKG, CXR, Labs, CBC, SMP, VA, PT, PTT) is not medically necessary.

EMG/NCS for bilateral upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 268-273. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Electrodiagnostic Testing Section; Chronic Pain Chapter

Decision rationale: Based on ODG guidelines, it reports that needle EMG or NCS are recommended depending on indications. Surface EMG is not recommended. EMG and NCS are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). EMG/NCS are separate studies and should not necessarily be done together. This is a duplicate request. The request for EMG/NCS of the bilateral upper extremities was already approved on 10/24/2014. Since this is a duplicate request, this request for EMG/NCS of the bilateral upper extremities is not medically necessary.