

Case Number:	CM14-0211206		
Date Assigned:	12/24/2014	Date of Injury:	02/14/2003
Decision Date:	02/20/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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: Texas, California
 Certification(s)/Specialty: Family Practice

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 59 year old female patient who sustained a work related injury on 2/14/2003. Patient sustained the injury due to cumulative trauma. The current diagnoses include cervicgia and lumbago. Per the doctor's note dated 11/19/14, patient has complaints of pain in neck, shoulders and back at 4/10. Physical examination of the cervical spine and bilateral upper extremities revealed tenderness, decreased flexion, decreased extension, decreased rotation, decreased left lateral bending and decreased right lateral bending. The current medication lists include Dulcolax, Oxycodone, Morphine, Effexor XR Morphine Sulfate Extended-Release (MSER), an NSAID, and Amitiza. The patient has had X-ray of hands 01/20/09 that revealed mild degenerative arthritis; X-ray of the cervical spine on 03/25/09 that revealed no postoperative radiologic complications; Computed tomography on 11/06/12, and Electromyography (EMG) report on 01/10/12 that revealed normal electro diagnostic studies upper extremities. The patient had received epidural steroid injection (ESI) without improvement in the symptoms. The patient underwent an anterior cervical discectomy and fusion at C4-5 and C-6 on 07/2004; a right carpal tunnel release (CTR) on 06/06 and left CTR 08/2006; revised fusion anteriorly at C5-C6in 07/2007 with slight improvement and a posterior instrumented fusion at C5-6 on 09/23/08. The patient has received an unspecified number of PT and electro acupuncture visits for this injury. He has had a urine drug toxicology report on 11/20/14 that was positive for opioid and benzodiazepines.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS of the Cervical Spine and Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation ODG, Neck and Upper Back and Forearm, Wrist, & Hand

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

Decision rationale: Per ACOEM chapter 12 guidelines, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." Per the ACOEM guidelines cited below, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out..... 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." The patient has had Electromyography (EMG) report on 01/10/12 that revealed normal electro diagnostic studies upper extremities. Any significant changes in objective physical examination findings since the last electro diagnostic study that would require a repeat electro diagnostic study were not specified in the records provided. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. A detailed response to a complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. The medical necessity of the request for EMG/NCS of the Cervical Spine and Bilateral Upper Extremities is not established.

CT Myelogram of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG, Neck & Upper Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Neck & Upper Back (updated 11/18/14) Myelography

Decision rationale: Per the ACOEM chapter 8 guidelines cited below "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out." Per the ACOEM chapter 8 guidelines cited below recommend "MRI or CT to evaluate red-flag diagnoses as above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1

month bone scans if tumor or infection possible, not recommended: Imaging before 4 to 6 weeks in absence of red flags."Per the ODG guidelines cervical myelography is "Not recommended except for selected indications below, when MR imaging cannot be performed, or in addition to MRI. Myelography or CT-myelography may be useful for preoperative planning."ODG Criteria for Myelography and CT Myelography include "1. Demonstration of the site of cerebrospinal fluid leak (postlumbar puncture headache, postspinal surgery headache, rhinorrhea, or otorrhea). 2. Surgical planning, especially in regard to the nerve roots; a myelogram can show whether surgical treatment is promising in a given case and, if it is, can help in planning surgery. 3. Radiation therapy planning, for tumors involving the bony spine, meninges, nerve roots or spinal cord. 4. Diagnostic evaluation of spinal or basal cisternal disease, and infection involving the bony spine, intervertebral discs, meninges and surrounding soft tissues, or inflammation of the arachnoid membrane that covers the spinal cord. 5. Poor correlation of physical findings with MRI studies. 6. Use of MRI precluded because of: a. Claustrophobia b. Technical issues, e.g., patient size c. Safety reasons, e.g., pacemaker d. Surgical hardware."Patient did not have any progressive neurological deficits that are specified in the records provided. Findings suggestive of suspicious for tumor, infection, fracture, or other red flags were not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. Prior PT visits notes were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. A plan for an invasive procedure of the cervical spine was not specified in the records provided. The medical necessity of the requested CT Myelogram of the cervical spine is not established.