

Case Number:	CM14-0214650		
Date Assigned:	01/07/2015	Date of Injury:	12/08/2009
Decision Date:	02/24/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	12/22/2014

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: 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 (IW) is a 53-year old man with a date of injury of December 8, 2009. The mechanism of injury was documented as a cumulative trauma. The injured workers working diagnoses are status post C5-C6 ACDF in April 2010; status post L3 through L5 posterior lumbar instability fusion PLIF on December 15, 2010; cervical radiculopathy; lumbar radiculopathy; history of alcohol abuse with elevated liver function test and urine drug screen positive for alcohol with recent cessation of alcohol. According to documentation in a May 27, 2014 progress note, the injured workers first cervical spine epidural steroid injection (ESI) was performed on December 28, 2013. The injection provided greater than 50% relief in symptoms. The IW reports 10 to 14 months of relief before the pain returned. A second cervical ESI was scheduled for July 7, 2014. It appears that the IW received the cervical ESI to the C7-T1 interspace on July 27, 2014. The subsequent progress noted does not provide evidence of objective functional improvement. Pursuant to the progress note dated November 20, 2014, the IW complains of significant neck pain that radiates to the bilateral upper extremities to the hand. The IW also complains of low back pain with radiation into the right L5 distribution and into the big toe. Examination of the cervical spine reveals tenderness to the cervical paraspinal musculature with muscle spasms. Cervical compression and Spurlings test caused significant radicular pattern of pain, much more on the left. Examination of the lumbar spine revealed decreased range of motion. Straight leg raise testing caused significant distribution of burning pain in the lateral calf down into the dorsum of the foot to the big toe. Current medications include Norco 10/325mg, Neurontin 600mg, and Tizanidine 4mg. EMG/NCV studies were

performed on October 30, 2013, which showed chronic left L5 radiculopathy and axonal polyneuropathy. The treating physician reports the IW had recent EMG/NCV of the bilateral upper and lower extremities on October 20, 2014. He reports he does not have results of the lower extremities, only the upper extremities. The treating physician later reports that the EMG/NCV of the bilateral lower extremities was abnormal; however, the findings were not documented. Reportedly, EMG/NCV of the upper extremities showed significant bilateral carpal tunnel as well as some elbow involvement. The treating physician is requesting repeat EMG study of the lower extremities. He is also recommending medication refills, and a repeat cervical ESI. The current request is for cervical epidural steroid injection X 2 (level not documented), and electromyography.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Injection times 2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Neck Section, Epidural steroid Injections

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, cervical epidural steroid injection times 2 is not medically necessary. Epidural Steroid Injections are recommended as an option for treatment of radicular pain. Criteria for the use of epidural steroid injections are enumerated in the official disability guidelines. These criteria include, but are not limited to, radiculopathy must be documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing; initially unresponsive to conservative treatment; in the therapeutic phase, repeat blocks should be offered if there is at least 50% pain relief for 6 to 8 weeks, with a general recommendation of no more than four blocks per year; repeat injections should be based on continued objective documented pain and functional response, etc. See the ODG for additional criteria and details. In this case, the injured workers working diagnoses are status post C5-C6 ACDF in April 2010; status post L3 through L5 posterior lumbar instability fusion PLIF on December 15, 2010; cervical radiculopathy; lumbar radiculopathy; history of alcohol abuse with elevated liver function test and urine drug screen positive for alcohol with recent cessation of alcohol. The documentation shows the injured worker had a Cervical Epidural Steroid Injection December 28, 2013. Reportedly, the injection provided greater than 50% relief and symptoms. The pain returned in 10 to 14 months. A second Cervical Epidural Steroid Injection was given July 7, 2014. Subsequent progress notes do not provide evidence of objective functional improvement. More specifically, there was no evidence that the epidural steroid injection provided greater than 50% relief in symptoms. The guidelines recommend repeat injections based on continued objective documented pain and functional response. There was none associated with the July 2014 Cervical Epidural Steroid Injection. Consequently, absent clinical documentation supporting a 50% pain response for 6 to 8 weeks with no documented objective pain and

functional response as a result of the cervical epidural injection; therefore, Cervical Epidural Steroid Injection times 2 is not medically necessary.

Electromyography: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck Section, EMG/NCV

Decision rationale: Pursuant to the Official Disability Guidelines, EMG is not medically necessary. NCV are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, recommended if the EMG is not clearly radiculopathy or clearly -4 to differentiate radiculopathy from other neuropathies. There is minimal justification for performing your conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate the cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than cervical radiculopathy, but these studies can result in unnecessary overtreatment. In this case, the injured workers working diagnoses are status post C5-C6 ACDF in April 2010; status post L3 through L5 posterior lumbar instability fusion PLIF on December 15, 2010; cervical radiculopathy; lumbar radiculopathy; history of alcohol abuse with elevated liver function test and urine drug screen positive for alcohol with recent cessation of alcohol. The documentation states the injured worker had an EMG/NCV of the bilateral upper and lower extremities on October 20, absent 2014. The results of the EMG/NCV of the lower extremities were not available to the treating physician. The treating physician then requested an EMG/NCV of the lower extremities. The burden is on the treating physician to obtain medical records and or electrodiagnostic studies. It is inappropriate to order repeat EMG/NCV studies of the lower extremities performed 10 days prior because the treating physician did not have the report in his medical record. Missing EMG/NCV studies performed 10 days prior to a new request because the treating physician did not have the EMG/NCV result in his possession is not a medically necessary reason to repeat the studies. Consequently, repeat EMG/NCV studies of the lower extremities are not medically necessary.