MAXIMUS Federal Services

Case Number:	CM15-0120317		
Date Assigned:	06/30/2015	Date of Injury:	11/04/2008
Decision Date:	07/31/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/22/2015

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: Emergency 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 is a 57-year-old female who sustained an industrial injury on 11/4/2008 resulting in radiating neck pain. The injured worker was diagnosed with cervical spondylosis, cervical myofascial pain syndrome, and left C7-8 radiculopathy. Treatment has included TENS unit, acupuncture, physical therapy, medication, left C5-6 and C6-7 anterior cervical decompression and fusion. Treatments have resulted in short-term symptom relief, but the injured worker reports worsening pain radiating to the left arm towards the hand with numbness and weakness to the arm. The treating physician's plan of care includes electromyography and nerve conduction studies to the left arm, and a referral for C7-T1 interlaminar epidural steroid injection. Work status at present is not addressed in provided documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS of the left arm: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182 and 272.

Decision rationale: EMG and NCV requested by provider are 2 different tests, testing for different pathologies. If one test is not recommended, this requested will be considered not medically necessary as per MTUS independent medical review guidelines. As per ACOEM Guidelines, Nerve Conduction Velocity Studies is not recommended for repeat "routine" evaluation of patients for nerve entrapment. It is recommended in cases where there are signs of median or ulnar nerve entrapment. There is no change or findings on physical exam consistent with carpal tunnel syndrome or any other nerve entrapment findings. There is no rationale provided for requested test. NCV is not medically necessary. As per ACOEM Guidelines, EMG is not recommended if prior testing, history and exam is consistent with nerve root dysfunction. EMG is recommended if pre procedure or surgery is being considered. Pt has not had any documented changes in neurological exam or complaints. Patient has obvious radiculopathy and it is not clear why testing is requested for a chronic obvious condition. Epidural steroid injection was found not medically necessary in this review and in utilization review as well. EMG is not medically necessary. EMG and NCV of left upper extremity is not medically necessary.

Referral to a pain management specialist, cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 3 Initial Approaches to Treatment Page(s): 1 and 92.

Decision rationale: As per ACOEM and MTUS guidelines, referrals may be appropriate if the caretaker is not able to manage patient's pain and function beyond their capability and after failure of conservative management. Reason for referral was for epidural steroid injection, which is not medically necessary in this medical review and utilization review. Consultation to a pain management specialist is not medically necessary.

Left C7-T1 Interlaminar Epidural Steroid Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESI) Page(s): 46.

Decision rationale: As per MTUS Chronic Pain Guidelines, Epidural Steroid Injections (ESI) may be useful in radicular pain and may be recommended if it meets criteria: 1) Goal of ESI: ESI has no long-term benefit. It can decrease pain in short term to allow for increasingly active therapy or to avoid surgery. The documentation fails to provide rationale for ESI besides pain control. There is no long-term plan. Fails criteria. 2) Unresponsive to conservative treatment. There is no appropriate documentation of prior conservative therapy attempts. There is no failure of conservative therapy. Patient has approved physical therapy. Fails criteria. Patient fails multiple criteria for lumbar epidural steroid injection. Lumbar epidural steroid injection is not medically necessary.