

Case Number:	CM15-0173082		
Date Assigned:	09/15/2015	Date of Injury:	09/01/2014
Decision Date:	10/14/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/02/2015

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: North Carolina
 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:

The injured worker is a 48 year old female, who sustained an industrial injury on September 01, 2014. The injured worker was diagnosed as having cervical spinal stenosis, cervical pain, and shoulder pain. Treatment and diagnostic studies to date has included magnetic resonance imaging of the cervical spine, physical therapy, medication regimen, acupuncture, x-rays of the neck and shoulder, and magnetic resonance imaging of the cervical spine. In a progress note dated August 19, 2015 the treating physician reports complaints of dull, aching, shooting, electric-like, and burning pain to the neck, upper back, mid-back, right shoulder, right arm, and right elbow with the neck pain radiating to the right upper extremity and associated symptoms of headaches, numbness, tingling, and weakness to the right arm and hand. Examination performed on August 19, 2015 was revealing for decreased range of motion to the cervical spine with pain, positive Spurling's test bilaterally, decreased motor strength to the left abductor pollicis brevis, and positive Hoffman's test bilaterally. On August 19, 2015, the injured worker's pain level was noted to be a 3 at its best and an 8 at its worst on a scale of 0 to 10 with 80% of the pain to the neck and 20% of the pain to the right arm. On August 19, 2015, the treating physician noted prior magnetic resonance imaging of the cervical spine performed on August 12, 2015, revealing for multilevel degenerative disc disease with "moderate to severe neural foraminal stenosis at multiple levels. On August 19, 2015, the treating physician noted an x-ray performed on January 23, 2015 that was remarkable for "moderate degenerative spondylosis". On August 19, 2015, the treating physician requested cervical epidural injection at cervical seven through thoracic one to improve the injured worker's pain and functional status along with avoiding an increase in the

use of the injured worker's medications. On August 19, 2015, the treating physician also requested an electromyogram with nerve conduction study of bilateral upper extremities to rule out cervical spine radiculopathy versus peripheral nerve entrapment due to examination results of extremity sensory impairment and symptoms of numbness and tingling. On August 27, 2015, the Utilization Review determined the requests for cervical epidural injection at cervical seven through thoracic one and an electromyogram with nerve conduction study of bilateral upper extremities to be non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical epidural injection at C7-T1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two 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 two nerve root levels should be injected using transforaminal 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 six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The patient has the documentation of back pain however there is no included imaging or nerve conduction studies in the clinical documentation provided for review that collaborates dermatomal radiculopathy found on exam for the requested level of ESI. Therefore, criteria have not been met and the request is not medically necessary.

EMG/NCS of bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)Forearm, Wrist & Hand.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: 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; Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. 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 assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags or subtle physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.