

<b>Case Number:</b>	CM13-0032426		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	07/20/2010
<b>Decision Date:</b>	02/06/2014	<b>UR Denial Date:</b>	09/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 physician 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:

The patient is a 32-year-old female who reported an injury on 07/20/2010 after developing neck pain that radiated into the bilateral upper extremities. The patient underwent a cervical MRI that revealed there was minimal disc desiccation of the C4-5 and C5-6 without cord or nerve root impingement. The patient's treatment history included medications, physical therapy, acupuncture, a TENS unit, myofascial release, and injections. The patient's most recent clinical evaluation reported bilateral numbness of the hands. Physical findings included a left-sided positive Tinel's, Phalen's, and Durkan's test on the left side. Sensational disturbances involving the thumb, index finger and long finger on the left side with a positive nerve compression test of the wrist was also documented. It was also noted that the patient did receive temporary relief from diagnostic steroid injections to the wrist to support the diagnosis of carpal tunnel syndrome. The patient's diagnoses included carpal tunnel syndrome, de Quervain syndrome and degenerative disc disease of the cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ACUTPUNCTURE TREATMENT 2 X WK X 6 WKS, PR-2 DATED 8/22/13:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The requested acupuncture treatment 2 times a week for 6 weeks is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient previously underwent acupuncture treatment with a decrease in pain. It is noted within the documentation that the patient previously underwent a total of 5 acupuncture visits. Therefore, California Medical Treatment Utilization Schedule recommends that continuation of acupuncture treatments be based on documentation of increased functional benefit. As the documentation does provide evidence that a patient had a decrease in pain levels as a result of the prior treatment, continuation of treatment would be supported. However, the requested 12 additional acupuncture treatments do not allow for timely reassessment and evaluation for efficacy of treatment and would be considered excessive. As such, the requested acupuncture treatment 2 times a week or 6 weeks is not medically necessary or appropriate.

**BILATERAL UPPER EXTREMITY EMG/NCV:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The requested bilateral upper extremity EMG/NCV would not be medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient previously underwent an EMG/NCV. It is noted within the documentation that the patient did have positive findings for radiculopathy as a result of the electromyography study. However, the results of the NCV were not provided. Additionally, the independent interpretation of that electrodiagnostic study was not provided for review. Therefore, there was no way to determine if the patient needs an additional study. American College of Occupational and Environmental Medicine do recommend electrodiagnostic studies to clarify/delineate neurological deficits from radiculopathy and neuropathy. Although the clinical documentation does not clearly identify if the patient's pain is radicular or neuropathic in nature, there has not been a significant change in the patient's presentation to support an additional electrodiagnostic study. As such, the requested bilateral upper extremity EMG/NCV with [REDACTED] prescribed 08/22/2013 is not medically necessary or appropriate.