

<b>Case Number:</b>	CM13-0037898		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	03/31/2006
<b>Decision Date:</b>	04/04/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2013

### 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 Internal Medicine and Emergency Medicine and is licensed to practice in Florida. 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:

This patient is a 45-year-old with a date of injury of 03/31/06. A progress report associated with the request for services, dated 09/30/13, identified subjective complaints of worsening low back pain radiating into the legs bilaterally. The patient also complained of neck pain radiating in to the right upper extremity with tingling. The objective findings included lumbar paraspinal tenderness with normal reflexes, sensation and motor function bilaterally. She also complained of cervical paraspinal tenderness with normal reflexes, sensation and motor function bilaterally. An MRI on 04/30/12 revealed disc protrusion at L3-4 and bulge at L4-5. The diagnoses included lumbar disc herniation with radiculopathy as well as cervical and lumbar sprain. The treatment has included home exercises, physical therapy, and acupuncture in January of 2013, epidural lumbar neuroplasty with injection as well as facet joint injections on 06/10/13. The patient was not on any prescription medications. A Utilization Review determination was rendered on 10/16/13, recommending non-certification of "acupuncture with electrical stimulation, manual stimulation and lumbar stabilization exercises 2 times per week for 3 weeks; MRI of the cervical spine; orthopedic consult/medication management visit to [REDACTED]; pain management consult with [REDACTED]".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture with electrical stimulation, manual stimulation and lumbar stabilization exercises two (2) times per week for three (3) weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

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

**Decision rationale:** The Acupuncture Medical Treatment Guidelines indicate that acupuncture is used as an option when pain medication is reduced or not tolerated. It further states that acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range-of-motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The frequency and duration of acupuncture is listed as: Time to produce functional improvement: 3 to 6 treatments; Frequency: 1 to 3 times per week; and Optimum duration: 1 to 2 months. It is noted that acupuncture treatments may be extended if functional improvement is documented. In this case, the patient has had acupuncture in the same year without documentation of functional improvement necessary to extend further treatments. Therefore, there is no documented medical necessity for additional acupuncture as requested.

**MRI of the cervical spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, MRI.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that for cervical nerve root compression, no diagnostic studies are indicated for four to six (4-6) weeks in the absence of progressive motor weakness. The criteria for ordering special studies such as an MRI are listed as: Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; and Clarification of the anatomy prior to an invasive procedure. Additionally, recent evidence indicates cervical disc annular tears may be missed on MRIs as well as a 30% false-positive rate in patients without symptoms and under the age of 30. The Official Disability Guidelines (ODG) state that an MRI is recommended with certain indications. These include: Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurological signs or symptoms present; Neck pain with radiculopathy if severe or progressive neurologic deficit; Chronic neck pain, radiographs show spondylosis, neurological signs or symptoms present; Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; Chronic neck pain, radiographs show bone or disc margin destruction; Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"; Known cervical spine trauma: equivocal or positive plain films with neurological deficit; and Upper back/thoracic trauma spine trauma with neurological deficit. In this case, the evaluation and request does not note any plain-film findings and there is no indication in the record of any of the above neurological abnormalities or other indications for an MRI and therefore no documented medical necessity for the study.

**Orthopedic consultation/medication management visit to [REDACTED]:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Intervention & Treatment, Opioids Page(s): 11, 79, 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Office Visits

**Decision rationale:** The Chronic Pain Guidelines indicate that those patients on controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care. The guidelines also indicate that there is no set visit frequency. The Official Disability Guidelines (ODG) indicate that, "The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment." The guidelines also indicate that that patient's conditions are extremely varied and that a set number of office visits per condition cannot be reasonably established. In this case, the denial for services was based upon an existing approval for an office visit. Therefore, the request is medically necessary.