

Case Number:	CM14-0138781		
Date Assigned:	09/05/2014	Date of Injury:	11/19/2012
Decision Date:	10/28/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	08/27/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/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 records presented for review indicate that this 61-year-old female was reportedly injured on November 19, 2012. The mechanism of injury is noted as cumulative trauma. The most recent progress note, dated August 8, 2014, indicates that there are ongoing complaints of neck pain radiating to the bilateral arms and hands, stiffness in bilateral hands, increasing weakness in the bilateral hands and is continually dropping things. The physical examination demonstrated tenderness along the cervical spine paraspinal muscles with spasms from C5 -T1. There was also tenderness and spasms at the right trapezius and decreased cervical spine range of motion secondary to pain. The physical examination of the lumbar spine reveals tenderness along the lumbar paravertebral muscles with decreased range of motion. There was a positive right-sided straight leg raise test and a positive Faber's test. Diagnostic imaging studies of the cervical spine revealed disc osteophyte complexes from C3 - C7. An MRI the lumbar spine revealed a disc bulge at L5 - S1 with a 4 mm superior disc extrusion. Nerve conduction study dated 7/18/14 of the bilateral upper extremities revealed denervation with subsequent reinnervation in the bilateral C7 root innervated muscles in the bilateral upper extremities with mild ongoing denervation, mild carpal tunnel syndrome in the left upper extremity. Diagnoses are listed cervical spine sprain/strain with radicular complaints; MRI evidence of 2 mm disk osteophyte at C3 to C4, C5 to C6, and C6 to C7, lumbar spine sprain/strain with radicular complaints ; MRI evidence of 2 mm disk bulge at L5 to S1 and 4mm superior disc extrusion. Previous treatment includes two sessions of acupuncture without much change. A request was made for additional acupuncture twice week for four weeks and bilateral epidural steroid injections at C6 - C7 and was not certified in the pre-authorization process on August 19, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL ACUPUNCTURE 2 TIMES WEEKLY FOR 4 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

Decision rationale: Per guidelines, "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e). In this case, there is no documentation of pain medications being reduced or not tolerated. There is no record of a plan for physical therapy and/or surgical intervention, that acupuncture can be used as adjunct to. Furthermore, there are no records of prior physical therapy to demonstrate any improvement in the pain level of function and to justify additional treatments. Therefore, the request for additional acupuncture is not considered medically necessary in accordance to MTUS guidelines.

BILATERAL CERVICAL EPIDURAL STEROID INJECTION AT THE LEVEL OF C6-7: Upheld

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

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

Decision rationale: Per guidelines, cervical epidural steroid injection is recommended as an option for treatment of radicular pain. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. 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. Criteria for the use of Epidural steroid injections include: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing and initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, there is clinical evidence of radicular pain into both upper extremities with Electrodiagnostic evidence of C7 radiculopathy. However, there is no documentation of trial and failure of conservative management such as physical therapy, oral NSAIDs or steroids in this injured worker. Nonetheless, it is not clear as to why B/L C6-7 ESI is requested while one intralaminar ESI would be adequate, if the criteria were met.

Therefore, the medical necessity of the request cannot be established, as the criteria are not met, based on the guidelines and submitted clinical information.