

Case Number:	CM14-0158395		
Date Assigned:	10/01/2014	Date of Injury:	04/12/2013
Decision Date:	10/29/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/26/2014

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 Orthopaedic Surgery 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:

This 27-year-old female payroll clerk sustained an industrial injury on 4/12/13. She reported gradual development of neck, upper back, bilateral shoulder and bilateral wrist pain associated with numbness and tingling. The 9/18/13 cervical, lumbar right shoulder and right wrist x-rays were reported normal. The thoracic spine x-ray impression was abnormal kyphosis with no scoliosis or disc space narrowing. The 2/11/14 upper and lower extremity EMG/NCV findings were within normal limits, with no electrophysiologic evidence of entrapment neuropathy, motor radiculopathy, or distal peripheral neuropathy. Records indicated that conservative treatment since February 2014 had included ice/heat, home exercise program, over-the-counter anti-inflammatory and analgesics as needed, work modification, and physical therapy. The 8/6/14 treating orthopedist report cited unchanged right upper extremity pain. The patient reported that she woke frequently at night if she laid on her right side due to pain and numbness/tingling. She also reported a burning sensation. She complained of sleep disturbance and anxiety. The patient was not working. Cervical exam findings documented moderate loss of bilateral lateral flexion with pain, pain with rotation, right parascapular tenderness, and negative Spurling's test. Shoulder exam was within normal limits. Right elbow exam documented full range of motion, right antecubital fossa tenderness, and positive Tinel's. Right wrist exam documented full range of motion with positive Tinel's sign. Lumbar spine exam documented normal gait, normal heel/toe walk, moderate loss of lumbar flexion/extension, L4/5 spinous process and paravertebral muscle tenderness, and right sacroiliac joint pain with compression. Upper and lower extremity neurologic exam was within normal limits. The diagnosis was carpal tunnel syndrome, sacroiliitis, cervical radiculitis, shoulder impingement/bursitis, shoulder sprain/strain rotator cuff, lumbosacral sprain/strain, and cervical myofascial sprain/strain. The treatment plan recommended consultation and treatment with a spine specialist for cervical and upper extremity

complaints, acupuncture 2-3 times per week for 4-6 weeks to increase range of motion and strengthening of the right shoulder, arm, and wrist, chiropractic treatment 2-3 times per week for 4-6 weeks for the right trapezius and neck, psychiatric consultation and treatment for anxiety, and sleep study due to interrupted sleep. The 8/25/14 utilization review denied the request for orthopedic spine specialist consultation as there was no clear clinical, imaging or electrophysiological evidence of a surgical lesion consistent with guidelines. The request for acupuncture was denied as there was no evidence whether this was an initial or additional request for treatment and guidelines criteria had not been met. The request for a sleep study was denied as there was no documentation of a condition/diagnosis for which a supervised sleep study was indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic Spine Specialist Consultation for the Cervical Spine and Upper Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines regarding surgical consultation/intervention

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 179-180, 209-210, 270; 34-35.

Decision rationale: The California MTUS guidelines state that referral for surgical consultation for the cervical spine is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms with activity limitation for more than one month or with extreme progression of symptoms. Guidelines require documented failure of conservative treatment to resolve radicular symptoms and clear clinical, imaging, and electrophysiological evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long-term. Shoulder, elbow, and wrist referral criteria also require clear evidence of a surgical lesion and failure of a range of motion and strengthening program. Guideline criteria have not been met. There is no current clinical evidence suggestive of red flag conditions or neurocompression. Radiographic and electrodiagnostic studies were reported as normal. There is no compelling reason to support the medical necessity of referral by the treating orthopedist to an orthopedic spine specialist. This is due to the lack of clinical, imaging and/or electrophysiological evidence of a potential surgical lesion consistent with guidelines. Therefore, this request of Orthopedic Spine Specialist Consultation for the Cervical Spine and Upper Extremities is not medically necessary and appropriate.

Acupuncture two times a week for four weeks for the Right Shoulder, Right Wrist and Right Arm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS acupuncture guidelines indicate that acupuncture may be used as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. 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. Guidelines state that 3 to 6 treatments allow time to produce functional improvement. Acupuncture treatments may be extended if functional improvement is documented as defined in the guidelines. Guideline criteria have not been met. Records indicate that this is the initial referral for acupuncture treatment. This request for 8 initial visits exceeds the initial guideline-recommended trial of 3 to 6 visits. The rationale for referral was to increase range of motion and strength; however current exam findings documented full upper extremity range of motion and strength. Therefore, this request of acupuncture two times a week for four weeks for the Right Shoulder, Right Wrist and Right Arm is not medically necessary and appropriate.

Sleep Study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG; Polysomnography

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Polysomnography

Decision rationale: The California Medical Treatment Utilization Schedule guidelines do not make recommendations relative to sleep studies (polysomnography). The Official Disability Guidelines recommend polysomnography after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Guideline criteria for Polysomnography include the combination of the following indications: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); & (6) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. Guideline criteria have not been met. Records indicated that pain disturbs sleep. There was no evidence in the reviewed records that the patient had been unresponsive to behavior intervention of sedation/sleep promoting medications. A psychiatric etiology of sleep dysfunction has not yet been excluded. Therefore, this request of Sleep Study is not medically necessary and appropriate.