

<b>Case Number:</b>	CM14-0056825		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	12/02/2010
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	04/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2014

### 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 Orthopedic Surgeon, Hand Surgeon and is licensed to practice in 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 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 injured worker is a 49-year-old female who reported an injury on 12/02/2010. The mechanism of injury was not stated. The current diagnoses include cervical intervertebral disc disorder with myelopathy, shoulder tendonitis, and cervicalgia. The most recent physician progress report submitted for this review is documented on 01/21/2014. Previous conservative treatment was not mentioned on that date. The injured worker presented with complaints of left upper extremity pain, right upper extremity pain, and sacroiliac joint pain. Physical examination revealed palpable tenderness at the bilateral upper extremities, tenderness at the bilateral sacroiliac joint regions, cervical spine tenderness, limited cervical range of motion, positive cervical compression testing, and positive Jackson's compression testing. Treatment recommendations included acupuncture twice per week for 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture treatment: twice a week for four weeks:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments. Therefore, the current request exceeds guideline recommendations. There is also no body part listed in the request. As such, the request is not medically necessary.

**Physical Therapy three times a week for four weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. There is no specific body part listed in the current request. Therefore, the current request is not medically appropriate. As such, the request is not medically necessary.

**Norco 10/325mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use of opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. There is no documentation of this injured worker's current utilization of this medication. There is no evidence of a failure of non-opioid analgesics. There is no documentation of a written pain consent or agreement for chronic use of an opioid. Additionally, there is no frequency listed in the request. As such, the request is not medically necessary.

**Omeprazole:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with

no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. There is no strength, frequency, or quantity listed in the request. Therefore, the request is not medically necessary.

**Left Carpal tunnel release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state carpal tunnel syndrome must be proved by positive findings on clinical examination and supported by nerve conduction studies prior to surgery. The injured worker does not maintain a diagnosis of carpal tunnel syndrome. There was no physical examination of the left upper extremity provided for review. There were no electrodiagnostic reports submitted for this review. The medical necessity has not been established. As such, the request is not medically necessary.