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| <b>Case Number:</b>   | CM15-0182275 |                              |            |
| <b>Date Assigned:</b> | 09/25/2015   | <b>Date of Injury:</b>       | 12/15/2010 |
| <b>Decision Date:</b> | 12/02/2015   | <b>UR Denial Date:</b>       | 08/17/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/14/2015 |

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 70 year old female who sustained an industrial injury on 12-15-2010. According to a progress report dated 06-22-2015, the injured worker reported pain and discomfort involving the right shoulder, right elbow, right wrist and forearm that radiated all the way up to her neck. She reported "beneficial effect" with electro-acupuncture treatment and wished to continue. There was no discussion in this report as to how many sessions had already been completed. "Mild" cervical paraspinous tenderness to palpation with myofascial tightness was noted. She had painful range of motion of the right shoulder. Without pain, she had 30% of normal range of motion and with pain she was able to get up to 70% of normal range of motion in all directions. Deep tendon reflexes were equal bilaterally. She had slight decreased strength in the right upper extremity compared to the left. Current diagnoses included status post fall, multiple body parts injury, right shoulder rotator cuff injury, right wrist fracture, non-displaced radial fracture, right wrist tendonitis, right shoulder rotator cuff tear, posttraumatic myofascial pain syndrome, right forearm radial fracture, right wrist sprain strain injury, right upper extremity sprain strain injury and right shoulder sprain strain injury. The provider noted that there was recommendation for the injured worker to discontinue Vimovo and try Celebrex for inflammation and pain control and Lidoderm patch. The injured worker reported back pain radiating down to the legs with sciatic nerve injury pain, so the provider was requesting authorization for further testing with MRI of the lumbosacral spine and electromyography (EMG) and nerve conduction velocity (NCV) study and a lumbar epidural steroid injection under fluoroscopic guidance. Physical therapy was also recommended. The provider noted that the

injured worker would not be able to return to her previous job due to severe injury. An authorization request dated 06-22-2015 was submitted for review. The requested services included lumbar epidural steroid injection x 1, MRI of the lumbar spine and EMG-NCV of the bilateral legs. According to a progress report dated 07-16-2015, the same subjective complaints and objective findings that were noted in the 06-22-2015 report were noted in this report. The injured worker reported that electro-acupuncture was the only treatment that had been helpful to control her pain and allow her to function. The provider noted that they were awaiting approval for MRI of the lumbosacral spine and EMG and NCV study of the low back. "The patient is to also try lumbar epidural steroid injection under fluoroscopic guidance." Physical therapy was recommended for increased pain and discomfort in the spine. The provider noted that the injured worker would not be able to return to her previous job due to severe injury. Authorization requests dated 07-16-2015 were submitted for review. The requested services included MRI of the lumbar spine, EMG-NCV, physical therapy, electro-acupuncture with infrared heat and myofascial release, back brace and acupuncture 2 x 6 infrared light myofascial release. On 08-17-2015, Utilization Review non-certified the request for MRI of the lumbar spine, EMG-NCV bilateral lower extremities, electro- acupuncture with infrared heat and myofascial release, two times a week for six weeks for the lumbar, right shoulder, left shoulder, right wrist and neck quantity 12, Pennsaid (unspecified dosage and quantity) and steroid epidural injection under fluoroscopic guidance lumbar spine quantity 1.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**MRI, Lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back chapter - Magnetic resonance imaging (MRIs).

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, and Low Back Complaints 2004, Section(s): Physical Examination, Special Studies.

**Decision rationale:** MTUS Guidelines support lumbar MRI studies if there is an adequate medical evaluation that supports either "red flag" conditions and/or persistent or progressive neurological dysfunction. Neither of these Guidelines standards have been met. There is no lumbar or lower extremity examination or history that supports a "red flag" condition or neurological dysfunction. The purpose and rationale for the requested lumbar testing is not documented. Under these circumstances, the request for the lumbar MRI is not supported by Guidelines and is not medically necessary. There are no unusual circumstances to justify an exception to Guideline recommendations.

**EMG/NCV, Bilateral lower extremities:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back chapter - Nerve conduction studies (NCS), EMG (electromyography).

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, and Low Back Complaints 2004, Section(s): Physical Examination, Special Studies.

**Decision rationale:** MTUS Guidelines support lumbar MRI studies if there is an adequate medical evaluation that supports persistent or progressive neurological dysfunction that is not well explained by other means. These Guidelines standards have been met. There is no lumbar or lower extremity examination or history that supports neurological dysfunction related to the lumbar spine. The purpose and rationale for the requested lumbar testing is not documented. Under these circumstances, the request for the EMG/NCV, Bilateral lower extremities is not supported by Guidelines and is not medically necessary. There are no unusual circumstances to justify an exception to Guideline recommendations.

**Electro Acupuncture with infrared head and myofascial release, two times a week for six weeks, Lumbar right shoulder, Left shoulder, Right wrist, Neck Qty: 12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007, and Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures.

**Decision rationale:** MTUS Guidelines recommend a trial of up to 6 sessions of acupuncture treatments with additional sessions optional depending upon objective results. There are subjective statements of benefits, but there is no documentation of how many sessions have been provided. In addition, there are no objective measures of functional benefits or positive impact on other treatment needs. Under these circumstances, the request for an additional Electro Acupuncture with infrared head and myofascial release, two times a week for six weeks, Lumbar right shoulder, Left shoulder, Right wrist, Neck Qty: 12 is not supported by Guidelines and is not medically necessary.

**Pennsaid (unspecified dosage and quantity): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation <http://www.pennsaid.com/>.

**Decision rationale:** MTUS Guidelines are very specific in stating that only FDA/Guideline approved agents are recommended. Pennsaid has FDA approval only for knee osteoarthritis, but there may be a reasonable exception for a trial for this individual's wrist arthritis, but the

recommended use including location is not documented. It is documented that oral anti-inflammatory medication are also being recommended on a concurrent basis. Guidelines are not supportive of the combination of topical and oral NSAIDs on a concurrent basis. Under these circumstances, the request for the Pennsaid (unspecified dosage and quantity) is not supported by Guidelines and is not medically necessary.

**Injection - Steroid epidural under Fluoroscopic guidance, Lumbar spine Qty: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** MTUS Guidelines support epidural injections under very specific circumstances. These include the presence of a dermatomal pattern radiculopathy with corresponding test results that are consistent with the clinical findings. There are no clinical findings supporting the request for the lumbar epidural. No radiculopathy is supported on a historical or objective examination basis. The request for the Steroid epidural under Fluoroscopic guidance, Lumbar spine Qty: 1 is not supported by Guidelines and is not medically necessary.