

Case Number:	CM15-0026823		
Date Assigned:	02/19/2015	Date of Injury:	08/19/2014
Decision Date:	04/17/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/12/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 40-year-old female, with a reported date of injury of 08/19/2014. The diagnoses include multiple level cervical disc desiccation, right shoulder impingement, cervical spine musculoligamentous sprain/strain, and herniated nucleus pulposus with radiculopathy at C5-6 and C6-7. Treatments have included oral medications, chiropractic treatment, a home exercise program, a transcutaneous electrical nerve stimulation (TENS) unit, ice, a cervical spine MRI on 11/13/2014, and an MRI of the right shoulder on 11/13/2014. The initial pain management evaluation dated 12/16/2014 indicates that the injured worker complained of right upper extremity pain. She described the pain as burning, sharp, and throbbing with numbness and tingling into the upper extremities. The physical examination showed decreased right shoulder range of motion, full range of motion of the left shoulder, decreased cervical range of motion, and mild weakness over the left upper extremity with elbow flexion and extension, acromioclavicular joint tenderness, tenderness over the trapezius and right paravertebral, and decreased sensation over the right C5-6 dermatome. The treating physician requested electromyography/nerve conduction velocity (EMG/NCV) of the bilateral upper extremities, eight chiropractic treatment visits for the cervical spine and right shoulder, and eight acupuncture sessions for the cervical spine and right shoulder for myofascial and neuropathic pain. On 01/30/2015, Utilization Review (UR) denied the request for electromyography/nerve conduction velocity (EMG/NCV) of the bilateral upper extremities, eight chiropractic treatment visits for the cervical spine and right shoulder, and eight acupuncture sessions for the cervical spine and right shoulder. The UR physician noted that there was no additional significant red flags that would

justify electrodiagnostic studies of the bilateral upper extremities; there were no chiropractic notes provided indicating the amount of chiropractic manipulation visits that the injured worker had completed to date or the response to any previous chiropractic manipulation treatment; and no evidence indicating whether the injured worker had any previous acupuncture treatment or response to any previous injection therapy. The non-MTUS Official Disability Guidelines, the American Association of Neuromuscular and Electrodiagnostic Medicine, the MTUS Chronic Pain Guidelines, and the MTUS Acupuncture Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV bilateral upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Treatment Integrated Treatment/Disability Duration Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags. There is evidence of neurologic dysfunction on exam. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. Conservative treatment has not been exhausted. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not certified.

Chiropractic treatment x8 cervical spine, right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual manipulation Page(s): 58-59.

Decision rationale: The California chronic pain medical guidelines section on manual manipulation states: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care not medically necessary. Recurrences/flare-ups need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines: A. Time to produce effect: 4 to 6 treatments Manual manipulation is recommended form of treatment for chronic pain. However, the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request is for 8 sessions. This does not meet criteria guidelines and thus is not certified.

Acupuncture x8 cervical spine, right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California chronic pain medical treatment guidelines section on acupuncture states: 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. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. 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. Time to produce functional improvement is 3-6 treatments and frequency is 1-3 times per week. The requested amount of session is in excess of the recommendation unless improvement is noted by 3-6 sessions. Therefore, the request is not certified.