

<b>Case Number:</b>	CM15-0212565		
<b>Date Assigned:</b>	11/04/2015	<b>Date of Injury:</b>	05/15/2014
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2015

### 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, 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 39 year old female who sustained an industrial injury on 05-15-2014. A review of the medical records indicated that the injured worker is undergoing treatment for brachial plexus lesion and cervical intervertebral disc degeneration. The injured worker is status post anterior and middle scalene muscle blocks on 09-10-2015. According to the treating physician's progress report on 09-29-2015, the injured worker was examined post scalene injection. Examination demonstrated continued reduction in range of motion at the right shoulder with scalene spasm and decreased sensation to light touch and pinprick in the right upper extremity versus the left upper extremity. Documentation revealed the injured worker's pain was reduced from 7 out of 10 to 3 out of 10 on the pain scale with symptoms now returning. Prior treatments have included diagnostic testing, a right scalene block and medications. No other therapeutic modalities were noted. Current medications were listed as Norco and Neurontin. Treatment plan consists of continuing medication regimen and the current request for right scalene Botox injection under ultrasound and EMG guidance and acupuncture therapy twice a week for 6 weeks to the cervical spine. On 10-08-2015 the Utilization Review determined the request for right scalene Botox injection under ultrasound with EMG guidance and acupuncture therapy twice a week for 6 weeks to the cervical spine was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right scalene botox injection under ultrasound and EMG guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Botulinum toxin (Botox Myobloc).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Botulinum toxin (Botox Myobloc).

**Decision rationale:** The claimant is a 39 year-old female with date of injury of 5/15/2014. Diagnosis is degenerative disc disease of cervical spine and upper back pain. The request is for repeat Botox injection to the right scalene muscle. There is a lack of documentation of pain and functional assessment in this case. There is no evidence of functional deficits to include range of motion and strength. The amount of time of pain relief from the previous injection is not reported. Botox injection is not recommended for thoracic outlet syndrome, the diagnosis in this case. There are no exceptional factors to warrant repeat scalene muscle Botox injections. Given the lack of information submitted, the request is not medically necessary or appropriate.

**Acupuncture 2x6 weeks, cervical:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** In this case, the request is for 12 sessions of acupuncture. No rationale for this therapy is provided in the clinical notes submitted. There is no baseline pain and functional assessment. A note from 9/29/2015 states that the patient has continued symptoms and lack of functional improvement or ability to manage symptoms with conservative treatment. It is unclear how acupuncture is expected to benefit the patient's current treatment plan. The request for 12 sessions also exceeds recommended guidelines. Three to six sessions are generally recommended with additional sessions based upon the patient's response to treatment. Therefore the request is not medically necessary or appropriate.