

Case Number:	CM15-0054026		
Date Assigned:	03/27/2015	Date of Injury:	06/28/2012
Decision Date:	05/14/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/23/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 56-year-old male who reported a hyperextension injury on 06/28/2012. The only clinical documentation submitted for review is a Panel Qualified Medical Evaluation dated 06/13/2014. The injured worker is diagnosed with sprain of unspecified site of the shoulder and upper arm as well as lumbosacral sprain. The injured worker presented on 06/13/2014 for a Panel Qualified Medical Evaluation. The injured worker reported low back pain and right shoulder pain. The current medication regimen includes famotidine, lisinopril, hydrochlorothiazide, simvastatin and finasteride. Upon examination, there was tenderness over the bicep muscle on the right, 5/5 motor strength, 2+ deep tendon reflexes, negative impingement sign, and intact sensation. The provider indicated the injured worker's future medical needs included maintenance and medication follow-up visits, therapy 3 times per week for 6 weeks, and repeat MRI and EMG/NCV studies. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2x4 weeks lumbar spine, right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California MTUS Guidelines state acupuncture is used as an option when pain medication has been 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. The current request for 8 sessions of acupuncture exceeds guideline recommendations. In addition, it is noted that the injured worker has been previously treated with a course of acupuncture. Documentation of significant functional improvement was not provided. Given the above, the request is not medically appropriate.

Lumbar spine epidural injection under fluoroscopy guidance for L5-S1 x3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: California MTUS Guidelines recommend epidural steroid injection as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there was no objective evidence of lumbar radiculopathy. There was no mention of an unresponsiveness to any recent conservative treatment to include active rehabilitation. In addition, the current request for 3 epidural steroid injections would not be supported, as the current guidelines do not support a series of 3 injections in either the diagnostic or therapeutic phase. Given the above, the request is not medically appropriate.

EMG/NCV Bilateral Lower Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state electromyography, including H-reflex test, may help identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In this case, there was no evidence of a motor or sensory deficit. There is no documentation of an attempt at any recent conservative treatment prior to the request for a repeat electrodiagnostic study. There is no evidence of a worsening or a progression of symptoms or examination findings to support the necessity for repeat testing. Given the above, the request is not medically appropriate.

MRI Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Indications for imaging- Magnetic resonance imaging.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: California MTUS/ACOEM Practice Guidelines states if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause. In this case, there was no evidence of a motor or sensory deficit upon examination. There is no documentation of a worsening or progression of symptoms or physical examination findings to support the necessity for a repeat MRI. There is also no mention of a recent attempt at any conservative treatment to include active rehabilitation. Given the above, the request is not medically appropriate.