

<b>Case Number:</b>	CM15-0083000		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	12/25/2014
<b>Decision Date:</b>	06/25/2015	<b>UR Denial Date:</b>	04/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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: 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 46 year old male, who sustained an industrial injury on 12/25/2014 after being involved in a motor vehicle accident, diagnostic studies at that time revealed disc protrusion and severe left sided stenosis at C6-C7 and electromyogram studies revealed left active C6 denervation. On provider visit dated 03/27/2015 the injured worker has reported neck pain, bilateral shoulder pain, upper, mid and low back pain and dizziness. On examination, the cervical spine revealed tenderness to palpation over the bilateral paraspinal musculature and upper trapezius muscles. Spurling's maneuver was positive on the left for pain radiation to the left mid-arm. Spurling maneuver was noted to be negative. And range of motion was noted to be decreased. Thoracolumbar spine inspection revealed tenderness to palpation with spasm, over the bilateral paraspinal musculature and interscapular musculature. Straight leg raise was negative. Range of motion was noted to be decreased. Bilateral shoulder's revealed no evidence of atrophy, tenderness to palpation over the parascapular musculature and posterior musculature. Impingement test was positive; bilaterally tenderness was noted over the subacromial region. Range of motion was decreased. The diagnoses have included cervical spine musculoligamentous sprain / strain with left upper extremity history of C6 radiculopathy, thoracolumbar musculoligamentous sprain / strain and bilateral shoulder periscapular strain with tendinitis and impingement. Treatment to date has included medication, MRI, laboratory studies, x-rays and electromyogram studies. The provider requested 12 acupuncture treatments as a trial, one updated MRI scan of the cervical spine, one home electrical muscle stimulation unit and one diagnostic ultrasound study of the shoulders.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**One diagnostic ultrasound study of the shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

**Decision rationale:** Regarding the request for ultrasound studies of the shoulders, California MTUS cites that ultrasonography for evaluation of rotator cuff is not recommended. Within the documentation available for review, there is no documentation of subjective/objective findings consistent with a condition/diagnosis for which ultrasound is supported given the lack of support for its use in the evaluation of the rotator cuff. Additionally, it is unclear what conservative treatment has been attempted prior to requesting imaging of the shoulders. Finally, there is no statement indicating what medical decision-making will be based upon the outcome of the study. In the absence of such documentation, the currently requested ultrasound studies of the bilateral shoulders are not medically necessary.

**One updated MRI scan of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, MRI.

**Decision rationale:** Regarding the request for repeat cervical MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. ODG states that repeat MRI is not routinely recommended in less there is a significant change in symptoms and or findings suggestive of significant pathology. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally, electrodiagnostic studies have demonstrated radiculopathy, and it is unclear how further imaging will change the current treatment plan. Finally, there is no documentation of changed subjective complaints or objective findings since the time of the most recent cervical MRI. In the absence of such documentation, the requested cervical MRI is not medically necessary.

**One home electrical muscle stimulation unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES devices). Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114-121 of 127.

**Decision rationale:** Regarding the request for One home electrical muscle stimulation unit, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines go on to state that electrical muscle stimulation is not generally recommended for treating chronic painful conditions. Within the documentation available for review, the requesting physician has not provided any peer-reviewed scientific literature to support the use of electrical muscle stimulation in the treatment of any of this patient's diagnoses. In the absence of clarity regarding those issues, the currently requested One home electrical muscle stimulation unit is not medically necessary.

**Twelve (12) acupuncture treatments:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Acupuncture.

**Decision rationale:** Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it is unclear what current concurrent rehabilitative exercises will be used alongside the requested acupuncture. Additionally, the current request for a visit exceeds the 6 visit trial recommended by guidelines. Unfortunately, there is no provision to modify the current request. As such, the currently requested acupuncture is not medically necessary.