

Case Number:	CM15-0117116		
Date Assigned:	06/25/2015	Date of Injury:	02/20/2015
Decision Date:	07/31/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/17/2015

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 (IW) is a 55 year old male who sustained an industrial injury on 02/20/2015. He reported an injury from slipping and falling on to all fours on a wet surface. The injured worker was diagnosed as having strain in the lumbar spine, contusions both knees and both wrists, strains in the bilateral shoulders/upper arms, and cervical strain. Treatment to date has included medications both oral and topical and MRI testing of the lumbar and cervical spine. Currently, the injured worker complains of pain in the neck that causes tingling and numbness down the right hand. He has complaint of intermittent moderate low back pain with radiation down the bilateral posterior thigh to the knee. Examination of the cervical spine reveals tenderness to palpation about the paracervical and trapezial musculature with muscle spasm and restricted range of motion secondary to pain. The right shoulder has tenderness to palpation about the anterolateral shoulder and supraspinatus with mild tenderness extending to the pectoralis. Range of motion is restricted and there is rotator cuff weakness. Examination of the right elbow reveals no tenderness or spasm, the right wrist/hand reveals tenderness to palpation over the 1st dorsal wrist compartment. There is weakness of grip strength and slightly restricted range of motion due to discomfort. Examination of the lumbosacral spine reveals increased tone and tenderness about the paralumbar musculature with tenderness at the midline thoraco-lumbar junction over the level of the L5-S1 facets and right greater notch. There are muscle spasms and a positive straight leg raise test bilaterally. The right knee has tenderness to palpation along the medial joint line with positive patellar crepitus. The left knee reveals tenderness to palpation along the medial and lateral line with mild effusion and minimal crepitus. Diagnostic tests of MRI of the lumbar spine (05/07/2015) shows a broad based disk bulge at L5-S1 causing moderate to severe right and moderate left neural foraminal narrowing. At L4-5 there is

moderate to severe right and moderate left neural foraminal narrowing secondary to a disk bulge, and there is a disk bulge at L3-L4 that causes mild neural foraminal narrowing and no canal stenosis. Mild hypertrophic facet degenerative changes are seen, and there is multi-level disk degeneration. The MRI of the cervical spine also shows disc protrusions with moderate proximal right neural foraminal narrowing at C6-C7. There is a central/left paracentral disk protrusion at C5-C6 with no significant neural foraminal narrowing or canal stenosis, and there are central disk protrusions at C2 through C4, causing no significant neural foraminal narrowing or canal stenosis, and there is a central disk bulge at C4-C5 that causes no significant neural foraminal narrowing or canal stenosis. The treatment plan is for acupuncture and nerve conduction testing. A request for authorization is made for the following: 1. Acupuncture for the neck, lower back, right shoulder, right elbow and both knees, twice a week for four weeks, and 2. Nerve Conduction Velocity/Electromyography of upper and lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture for the neck, lower back, right shoulder, right elbow and both knees, twice a week for four weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: 1. "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. Frequency and duration of acupuncture with electrical stimulation may be performed as follows: 1. Time to produce functional improvement 3-6 treatments 2. Frequency: 1-3 times per week 3. Optimum duration is 1-2 months 4. Treatments may be extended if functional improvement is documented. The request for acupuncture is for a total of 8 sessions. This is in excess of the recommendations. The patient must demonstrate functional improvement in 3-6 treatments for more sessions to be certified. Therefore, the request is in excess of the recommended initial treatment sessions and not medically necessary.

Nerve Conduction Velocity/Electromyography of upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

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, compute 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 or subtle physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. Previous MRI had already shown cervical pathology. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore the request is not medically necessary.