

Case Number:	CM15-0127321		
Date Assigned:	07/14/2015	Date of Injury:	11/18/2014
Decision Date:	08/07/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/01/2015

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 53 year old female, who sustained an industrial injury on 11/18/14. The injured worker has difficulty recalling events from the previous day such as what she ate and what activities she performed. The injured worker continues to complain of persistent left sided head pain/ache. She has light sensitivity/photophobia in which she needs to wear sunglasses most of the time; frequent, intermittent sharp stabbing (nerve type) pain over the entire head but mostly on the left side where she hit it on the windshield. She has pain/tingling sensations that she was experiencing radiating down both arms to the hands. The injured worker has difficulty talking for extended periods of time due to the left sided jaw pain she is experiencing caused by the facial nerve that runs through that area. The diagnoses have included head injury not otherwise specified. The documentation noted on 6/12/15 that the treatment plan to date has included physical therapy; home exercise program; discontinue amitriptyline and start effexor; acupuncture; motrin; tramadol, alternate with motrin and decrease activity so brain cells can continue to rest and heal with no driving, no computer work, no reading over 15 minutes at a time, no strenuous physical activity. The request was for acupuncture for the head/face, 6 sessions and electromyography/nerve conduction study of the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture for the head/face, 6 sessions: Overturned

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: 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 6 sessions. This is not in excess of the recommendations. The patient must demonstrate functional improvement in 3-6 treatments. Therefore the request is not in excess of the recommended initial treatment sessions and therefore medically necessary.

Electromyogram (EMG)/Nerve conduction study (NCS) of the bilateral upper extremities:
Upheld

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

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, computed 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 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. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore the request is not medically necessary.