

<b>Case Number:</b>	CM13-0005802		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	08/07/2012
<b>Decision Date:</b>	03/25/2014	<b>UR Denial Date:</b>	07/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a male patient who reported an injury on 08/07/2012. The mechanism of injury was not specifically stated. The only documentation submitted for this review is a Qualified Medical Evaluation conducted on 10/16/2013 by [REDACTED]. The patient is diagnosed with a herniated disc at L3-4, status post removal of herniated disc in 1993, status post removal of recurrent herniated disc in 1997, chronic lumbosacral strain, lumbar radiculopathy, cervical strain, degenerative disease in the cervical spine, possible cervical radiculopathy, left carpal tunnel syndrome, and borderline right carpal tunnel syndrome. The patient reported pain and numbness in the right and left fingers, ongoing shoulder pain, and stiffness in the neck. Physical examination revealed tenderness and spasm of the cervical spine with decreased range of motion, tenderness and spasm of bilateral shoulders with decreased range of motion, hyperesthesia of the right and left lateral arm, hyperesthesia in the right and left thumb, index and middle fingers, mild spasm in the paraspinal muscles of the lower back, negative straight leg raising, weak grip strength bilaterally, and hyperesthesia over the right lateral calf. A review of medical records was also completed at that time. Treatment recommendations included continuation of current treatment including epidural blocks, medication, physical therapy, and exercise.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiro (Unspecified): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**Decision rationale:** California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. As per the documentation submitted, the patient has previously completed a course of chiropractic therapy. However, documentation of the previous course of treatment with treatment duration and efficacy was not provided for review. Therefore, ongoing treatment cannot be determined as medically appropriate. Additionally, the frequency and duration of treatment was not specified in the request. Based on the clinical information received, the request is non-certified.

**PT (Unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. As per the documentation submitted, the patient has completed a course of physical therapy. However, documentation of the previous course was not provided for review. Therefore, ongoing treatment cannot be determined as medically appropriate. Additionally, the frequency and duration of treatment was not specified in the request. Based on the clinical information received, the request is non-certified.

**Massage Therapy (Unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

**Decision rationale:** California MTUS Guidelines state massage therapy is recommended as an option. Treatment should be in adjunct to other recommended treatment and should be limited to 4 to 6 visits. As per the documentation submitted, the patient has previously participated in massage therapy. Documentation of the previous course of treatment was not provided for review. Additionally, the frequency and duration of treatment was not specified in the request. Based on the clinical information received, the request is non-certified.

**Rehab Care (Unspecified): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state comfort is often a patient's first concern for neck and upper back complaints. If treatment response is inadequate, prescribed pharmaceuticals or physical methods can be added. The medical necessity for the requested service has not been established. The frequency and duration of treatment was also not specified in the request. Based on the clinical information received, the request is non-certified.

**MRI Cervical Spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding the next steps, including the selection of an imaging test to define a potential cause. As per the documentation submitted, the patient's physical examination of the cervical spine only revealed tenderness to palpation with spasm and slightly diminished range of motion. There is no documentation of a significant change in the patient's physical examination that would indicate the need for an MRI. The medical necessity has not been established. There is also no evidence of a recent failure to respond to conservative treatment. Based on the clinical information received, the request is non-certified.

**MRI (R) Shoulder: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state primary criteria for ordering imaging studies include the emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program, or for clarification of the anatomy prior to an invasive procedure. As per the documentation submitted, the patient's physical examination of the right shoulder only revealed tenderness to palpation

with spasm and slightly decreased range of motion. There is no documentation of a significant change in the patient's symptoms or physical examination findings. Based on the clinical information received, the request is non-certified.

**Vicodin:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no documentation of objective functional improvement. Therefore, the request is non-certified.

**Anti-Inflammatories (Unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. There is no documentation of a failure to respond to first-line treatment with acetaminophen as recommended by California MTUS Guidelines. The specific medication with dosage, frequency, and quantity was not specified in the request. Therefore, the request is not medically appropriate. As such, the request is non-certified.