

<b>Case Number:</b>	CM14-0110012		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	12/10/2012
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	06/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2014

### 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. The expert reviewer is Board Certified in Anesthesiology and Pain Medicine 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 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/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:

The injured worker is a 33 year old female who sustained an injury on 12/10/12 due to cumulative trauma. The injured worker was followed for multiple complaints including neck pain and low back pain and left shoulder and right wrist pain. Medications included hydrocodone cyclobenzaprine and omeprazole. The injured worker previously saw both acupuncture and physical therapy and was given a neurostimulator unit. The injured worker was seen on 06/09/14 with continuing complaints of severe low back pain that was minimally improved with medications. The injured worker also described shoulder wrist and neck pain. On physical examination there was tenderness to palpation in the lumbar spine and tenderness and spasms in the cervical spine and upper extremities. The injured worker was continued on topical compounded medication and recommended for initial trial of acu and recommended for further acupuncture treatment at this visit. The requested treatment including urinalysis toxicology computed tomography scans of the cervical spine magnetic resonance image (MRI) of the cervical spine MRI of the right wrist MRI of the lumbar spine physical therapy for eight sessions continued acupuncture therapy for eight sessions consultation with internist for gastrointestinal issues were denied by utilization review on 06/09/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urinalysis toxicology:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Drug Testing. Decision based on Non-MTUS Citation ODG - TWC Pain Procedure Summary last updated 05/15/2014;Urine Drug Testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Urine Drug Testing.

**Decision rationale:** In regards to the request for urinalysis toxicology clinical documentation submitted for review did not identify any controlled substances currently prescribed to the injured worker. There were no identified risk factors for aberrant medication use or abuse. Therefore this reviewer would not have recommended this request as medically necessary.

**CT scan of the neck:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines Table 8-4 Page 172ODG - TWC Becj & Upper Back Procedure Summary last updated 04/14/2014; regarding Indications for imaging -- CT (computed tomography).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177.

**Decision rationale:** In regards to the request for computed tomography (CT) scans of the cervical spine this reviewer would not have recommended this request as medically appropriate. Physical examination presentation noted no clear evidence of neurological deficit in the upper extremities. There were no other red flag findings to support CT scans of the cervical spine or plain film radiographs of the cervical spine available for review. Therefore this reviewer would not have recommended this request as medically appropriate.

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation ODG - TWC Neck & Upper Back Procedure Summary last updated 04-14/2014; regarding MRI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177.

**Decision rationale:** In regards to the request for magnetic resonance image of the cervical spine this reviewer would not have recommended this request as medically appropriate. Physical examination presentation noted no clear evidence of neurological deficit in the upper extremities. There were no other red flag findings to support computed tomography scans of the cervical spine or plain film radiographs of the cervical spine available for review. Therefore this reviewer would not have recommended this request as medically appropriate.

**MRI of the right wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation ODG - TWC Forearm, Wrist and Hand Procedure Summary last updated 2/18/2014; regarding MRI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

**Decision rationale:** In regards to the request for magnetic resonance image of the right wrist this reviewer would not have recommended this request as medically appropriate. Physical examination findings did not identify any evidence of instability or deformity that would be concerning for internal derangement in the right wrist. No plain film radiographs of the right wrist were made available for review. Therefore this reviewer would not have recommended this request as medically appropriate or medically necessary.

**Physical Therapy 2x4 (lumbar, cervical, left shoulder): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Physical Medicine. Decision based on Non-MTUS Citation ODG - TWC Low Back Procedure Summary last updated 03/18/2014; Physical TherapyODG - TWC Shoulder Procedure Summary last updated 03/31/2014; Physical TherapyODG - TWC Neck & Upper Back Procedure Summary last updated 03/07/2014; Physical Therapy.

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

**Decision rationale:** In regards to the request for physical therapy for eight sessions for the lumbar cervical and left shoulder this reviewer would not have recommended this request as medically necessary. Clinical documentation of prior response to physical therapy was not available for review. No specific goals were established for physical therapy to support its ongoing use for a two year old injury. Therefore this reviewer would not have recommended this request as medically indicated.

**Continued acupuncture sessions 2x4 (lumbar, cervical, left shoulder): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** In regards to the request for continued acupuncture therapy sessions for eight sessions this reviewer would not have recommended this request as medically appropriate. The injured worker previously attended acupuncture therapy treatment however it is unclear what if any functional benefit or pain reduction had been obtained with this therapy that would

have supported ongoing use. Given the lack of documentation of efficacy obtained with acupuncture therapy this reviewer would not have recommended this request as medically necessary.

**Consultation with an internist medicine physician (gastrointestinal issues): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG - TWC Pain Procedure Summary last updated 05/15/2014; office visits.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page(s) 32.

**Decision rationale:** In regards to the request for consultation with internist for gastrointestinal (GI) issues this reviewer would not have recommended this request as medically appropriate. From the last clinical records provided for review there was no indication of any substantial GI issues that would support referral to a specialist. At this time it is unclear how a specialist consult for the date of injury would result in any further information that would help delineate care. Therefore this reviewer would not have recommended this request as medically appropriate.

**Consultation with a GI specialist: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG - TWC Pain Procedure Summary last updated 05/15/2014; office visits.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page(s) 32.

**Decision rationale:** In regards to the request for consultation with gastrointestinal (GI) Specialist, this reviewer would not have recommended this request as medically appropriate. From the last clinical records provided for review there was no indication of any substantial GI issues that would support referral to a specialist. At this time it is unclear how a specialist consult for the date of injury would result in any further information that would help delineate care. Therefore this reviewer would not have recommended this request as medically appropriate.

**MRI of the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ODC - TWC Low Back Procedure Summary last updated 02/13/2014; regarding MRI's.

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

**Decision rationale:** In regards to the request for magnetic resonance image of the lumbar spine, this reviewer would not have recommended this request as medically appropriate. Physical examination presentation noted no clear evidence of neurological deficit in the upper extremities. There were no other red flag findings to support computed tomography scans of the cervical spine or plain film radiographs of the cervical spine available for review. Therefore this reviewer would not have recommended this request as medically appropriate.