

<b>Case Number:</b>	CM14-0176148		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	11/25/2013
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	10/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2014

### 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 General Preventive Medicine and is licensed to practice in Indiana. 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:

This employee is a 64 year old male with date of injury of 1/25/2013. A review of the medical records indicates that the patient is undergoing treatment for cervical, thoracic, and lumbar strain/sprain with radiculopathy and left shoulder tendinosis. Subjective complaints include continued 5/10 pain in the left shoulder, neck, and lower back. Objective findings include limited range of motion in the cervical, thoracic, and lumbar spine with tenderness to palpation of the paravertebrals; limited range of motion of the left shoulder. Treatment has included chiropractic sessions, steroid injections, shockwave therapy, Fluriflex, TGHOT, and Cyclobenzaprine. The utilization review dated 10/23/2014 non-certified 12 sessions of chiropractic manipulations, MRI of the cervical spine, LINT of lumbar spine, and urine toxicology.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continue chiropractic for evaluation and treatment to cervical spine, thoracic spine, lumbar spine, and left shoulder- two (2) times a week for six (6) weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation

**Decision rationale:** ODG recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated." Additionally, MTUS states "Low back: Recommended as an option. Therapeutic care- Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective /maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." Medical documents indicate that patient has undergone previous chiropractic sessions, which would not be considered in the 'trial period' anymore. The treating provider has not demonstrated evidence of objective and measurable functional improvement during or after the trial of therapeutic care to warrant continued treatment. As such, the request for Continue chiropractic for evaluation and treatment to cervical spine, thoracic spine, lumbar spine, and left shoulder- two (2) times a week for six (6) weeks is not medically necessary and appropriate.

**MRI to cervical spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177,182. Decision based on Non-MTUS Citation ODG) Neck and Upper Back, Magnetic resonance imaging (MRI)

**Decision rationale:** ACOEM 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 and Clarification of the anatomy prior to an invasive procedure". ODG states, "Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging.... Indications for imaging -- MRI (magnetic resonance imaging):- Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present- Neck pain with radiculopathy if severe or progressive neurologic deficit- Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present- Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present- Chronic neck pain, radiographs show bone or disc margin destruction- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"- Known cervical spine trauma: equivocal or positive plain films with neurological deficit- Upper back/thoracic spine trauma with neurological deficit". The treating physician has not provided evidence of red flags to meet the criteria above. Additionally, the employee had a

cervical MRI on 7/31/2014, and there is no mention of any acute changes to justify a new MRI. As such, the request for MRI of the cervical spine is not medically necessary.

**LINT to lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287,315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

**Decision rationale:** ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding inferential units, "Not recommended as an isolated intervention" and details the criteria for selection: - Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits." The treating physician's progress notes do not indicate that the patient has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. As such, current request for interferential unit is not medically necessary.

**Urine Toxicology:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Substance abuse Page(s): 74-96, 108-109. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009), pg 32 Established Patients Using a Controlled Substance

**Decision rationale:** MTUS states that use of urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. Additionally, "Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion) would indicate need for urine drug screening. There is insufficient documentation provided to suggest issues of abuse, addiction, or poor pain control by the treating physician. University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including

Prescribing Controlled Substances (May 2009) recommends for stable patients without red flags "twice yearly urine drug screening for all chronic non-malignant pain patients receiving opioids - once during January-June and another July-December". There is no documentation showing the employee to be starting a trial of opioids. There are no red-flag indications shown above that would be relevant for this employee getting a urine drug screen. As such, the request for urine toxicology is not medically necessary.