

<b>Case Number:</b>	CM14-0051274		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	10/01/2013
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	04/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 38-year-old female who reported an injury on 10/01/2013. The mechanism of injury was reported as continuous trauma due to typing, repetitive lifting of files, and working at a computer. The diagnoses included cervical musculoligamentous sprain/strain with radiculitis. Prior treatments included chiropractic therapy and acupuncture. Per the 03/12/2014 First Report of Injury, the injured worker reported neck pain, back pain, bilateral shoulder and arm pain, psychiatric complaints, and sleeping problems. Examination of the cervical spine noted tenderness to palpation and spasm with decreased range of motion and a positive distraction test. The injured worker was given prescriptions for Cyclobenzaprine and Omeprazole. The treatment plan included an interferential unit, hot and cold unit, urine toxicology, MRI of the cervical spine, EMG/NCV of the bilateral upper extremities, and a Functional Capacity Evaluation. A Functional Capacity Evaluation was requested to ensure the injured worker could safely meet the physical demands of her occupation. The Request for Authorization Form was submitted 03/12/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

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

**Decision rationale:** The request for MRI of the cervical spine is non-certified. The California MTUS/ACOEM Guidelines state, for most neck or upper back problems, special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. The criteria for ordering imaging studies includes: 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. The medical records provided indicate the injured worker was experiencing cervical spine tenderness on palpation and spasm with decreased range of motion. There is a lack of documentation regarding the failure of a recent trial of conservative care. There is no indication of the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program, or the intent to undergo an invasive procedure. Based on this information, the request is not supported. As such, the request for MRI of the cervical spine is non-certified.

**EMG 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): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Electromyography (EMG).

**Decision rationale:** The request for EMG of the bilateral upper extremities is non-certified. The California MTUS/ACOEM Guidelines state electromyography may help identify subtle, focal, neurological dysfunction in injured workers with neck or arm symptoms lasting more than 3 or 4 weeks. The Official Disability Guidelines further state, cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy but they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these tests can result in unnecessary overtreatment. The rationale for the request was not provided. The medical records provided indicate the injured worker was experiencing decreased motor strength in the right upper extremity at 4/5 and decreased sensation in the right anterolateral shoulder/arm. There is a lack of documentation of the failure of a recent trial of conservative care. There is no indication of any significant neurological deficits requiring further evaluation with electrodiagnostic studies. As such, the request for EMG of the bilateral upper extremities is non-certified.

**NCV of the bilateral upper extremities:** 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 Official Disability Guidelines, Neck.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Nerve conduction studies (NCS).

**Decision rationale:** The request for NCV of the bilateral upper extremities is non-certified. The California MTUS/ACOEM Guidelines state nerve conduction velocities may help identify subtle, focal, neurologic dysfunction in injured workers with neck or arm symptoms lasting more than 3 or 4 weeks. The Official Disability Guidelines further state, nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but they are recommended if the EMG is not clearly radiculopathy or clearly negative. The medical records provided indicate the injured worker was experiencing decreased motor strength in the right upper extremity at 4/5 and decreased sensation in the right anterolateral shoulder/arm. There is a lack of documentation regarding the failure of a recent trial of conservative care. There is no indication of any significant neurologic deficits requiring further evaluation with electrodiagnostic studies. Nonetheless, the guidelines state that nerve conduction studies are only recommended when EMGs are negative or do not clearly identify radiculopathy. As such, the request for NCV of the bilateral upper extremities is non-certified.

**Functional Capacity Evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Fitness for duty.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125-126. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty, Functional capacity evaluation (FCE).

**Decision rationale:** The request for Functional Capacity Evaluation is non-certified. The California MTUS Guidelines state an FCE may be required, showing consistent results with maximal effort demonstrating capacities below and employer verified physical demand analysis. The Official Disability Guidelines further state, Functional Capacity Evaluations are recommended prior to admission to a work hardening program. The medical records provided indicate a Functional Capacity Evaluation was requested to ensure the injured worker could safely meet the physical demands of her occupation. There is a lack of documentation to verify the injured worker had returned to work. There is also no indication the injured worker planned to participate in a work hardening program. Based on this information, the request is not supported. As such, the request for Functional Capacity Evaluation is non-certified.

**12 Chiro Manipulation treatments and evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

**Decision rationale:** The request for 12 chiro manipulation treatments and evaluation is non-certified. The California MTUS Guidelines state manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. The guidelines state a time to produce effect of 4 to 6 treatments. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. The medical records provided indicate the injured worker completed prior chiropractic therapy which helped her pain. There is a lack of documentation regarding the prior therapy to verify the number of sessions completed and functional improvements made. Nonetheless, the request for 12 chiropractic treatments exceeds the guideline recommendations. Based on this information, the request is not supported. As such, the request for 12 chiro manipulation treatments and evaluation is non-certified.

**Omeprazole 20mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

**Decision rationale:** The request for omeprazole 20 mg quantity 60 is non-certified. The California MTUS Guidelines recommend proton pump inhibitors for patients taking NSAIDs with current gastrointestinal problems or those at risk for gastrointestinal event. Risks for gastrointestinal event include: age greater than 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID use. The rationale for the request was not provided. A complete medication list was not provided. There is no indication the injured worker was experiencing current gastrointestinal problems or was at risk for gastrointestinal event. Based on this information, the request is not supported. As such, the request for omeprazole 20 mg quantity 60 is non-certified.

**Urine toxicology screening:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

**Decision rationale:** The request for urine toxicology screening is non-certified. The California MTUS Guidelines recommend drug testing as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. As of 03/12/2014, the injured worker was given prescriptions for cyclobenzaprine and omeprazole. A current medication list was not provided. There is no indication the injured worker was misusing her medications or that the provider

suspected her of misuse to warrant a urine drug screen. Based on this information, the request is not supported. As such, the request for urine toxicology screening is non-certified.

**IF unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The request for IF unit is non-certified. The California MTUS Guidelines state interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including returning to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. It is only indicated for injured workers whose pain is ineffectively controlled due to diminished effectiveness of medications or side effects. It may be appropriate if it has been documented and proven to be effective as directed or applied by the physician or provider licensed to provide physical medicine. There is a lack of documentation regarding the effectiveness of an interferential unit as applied by a physician or a licensed provider. There is no indication the injured worker's medications were ineffective or causing adverse side effects. There is also no indication the injured worker would be using the interferential unit in conjunction with other treatments. In addition, the submitted request does not specify the site, duration, or frequency of treatment. Based on this information, the request is not supported. As such, the request for IF unit is non-certified.

**hot and cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous-flow cryotherapy.

**Decision rationale:** The request for 1 hot and cold therapy unit is non-certified. The Official Disability Guidelines state continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. The effect on more frequently treated acute injuries has not been fully evaluated. The medical records provided indicate the injured worker was experiencing pain in the cervical spine, thoracic spine, and bilateral shoulders. There is no indication the injured worker wished to proceed with surgery or that surgery was being considered. The guidelines state that cold therapy units are only recommended for postoperative use. Based on this information, the request is not supported. As such, the request for 1 hot and cold therapy unit is non-certified.