

<b>Case Number:</b>	CM14-0060046		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	02/28/2014
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2014

### 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 33-year-old female with a reported date of injury on 02/28/2014. The mechanism of injury was reportedly caused by a slip. The injured worker did not fall. Her diagnoses included bilateral shoulder strain/sprain, cervical spine sprain/strain, and lumbar spine sprain/strain. Diagnostic studies included x-rays, the results of which were not provided. Pertinent surgical history was not provided. The injured worker presented with complaints of right shoulder pain, neck pain radiating to the right hand, low back pain radiating to the right foot, mid back pain and left shoulder pain. The injured worker's medication regimen included Tylenol and tizanidine. Upon physical examination, the injured worker presented with 5/5 motor strength throughout all muscle groups. In addition, the sensory exam revealed no deficits to fine prick, since noted bilaterally. The cervical spine physical exam revealed tenderness with palpation along the spinous process of C3-7 and bilateral paraspinal structures of C3-7. The cervical spine range of motion revealed flexion to 28 degrees, extension to 30 degrees, left lateral bending to 22 degrees, and right lateral bending to 18 degrees. In addition, there was tenderness noted upon palpation of the thoracic spine. The lumbosacral spine presented with tenderness along the spinous process of L3-5. Lumbar range of motion revealed flexion to 30 degrees, extension to 18 degrees and a positive straight leg raise bilaterally. Previous conservative care included physical therapy. The physician indicated that the Request for Authorization for MRI of cervical spine, lumbar spine, both shoulders and topical creams, drug screening and chiropractic treatment is requested to help reduce pain, spasms and increased motion. The clinical documentation dated 04/14/2014 indicates the patient underwent x-rays of the cervical spine, thoracic spine, lumbar spine and right shoulder on that date; the results of which were not provided within the documentation. She was also prescribed an interferential home unit for relief of pain at home. The Request for Authorization for chiropractic treatment 2 times 4 to

right shoulder, cervical spine lumbar spine, left shoulder, physiotherapy 2 times 4 to right shoulder, cervical spine, lumbar spine, left shoulder; decision for interferential treatment unit; decision for heating; x-ray of cervical spine; x-ray of thoracic spine; x-ray of lumbar spine; x-ray of right shoulder; decision for MRI of cervical spine; MRI of lumbar spine and MRI of the right shoulder was submitted on 04/28/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Chiropractic treatment 2x4 to right shoulder, cervical spine lumbar spine, left shoulder:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 203 and 298-299.

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

**Decision rationale:** The California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measureable gains and functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The Guidelines recommend time to produce effect is 4 to 6 treatments with a frequency of 1 to 2 times per week and a maximum duration of 8 weeks. The request for 8 chiropractic treatments exceeds the recommended guidelines. In addition, there is a lack of documentation related to the functional or therapeutic benefit related to previous chiropractic therapy. Therefore, the request for chiropractic treatment 2 times 4 to right shoulder, cervical spine, lumbar spine and left shoulder is not medically necessary.

#### **Physiotherapy 2x4 to right shoulder, cervical spine, lumbar spine, left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174, 212, 287-289.

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

**Decision rationale:** The California MTUS Guidelines recommend physical medicine as indicated. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend 8 to 10 visits over a 4 week period. According to the clinical information provided for review, the injured worker had previously participated in physical therapy, the number of physical therapy visits and the therapeutic or functional outcome was not provided. The request

for an additional 8 physical therapy visits exceeds the recommended guidelines. Therefore, the request for physiotherapy 2 times 4 to right shoulder, cervical spine, lumbar spine, left shoulder is not medically necessary.

**Interferential unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, 173-174 and 300.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

**Decision rationale:** The California MTUS Guidelines indicate the criteria for use of TENS would include documentation of pain of at least 3 months duration. There was evidence that other appropriate pain modalities have been tried including medication and failed. A 1-month trial period of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach. With documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. Other ongoing pain treatments should also be documented during the trial period including medication usage. In addition, there should be a treatment plan including the specific short and long term goals of treatment with a TENS unit should be submitted. The clinical information provided for review indicates the injured worker has previously utilized a TENS unit. There is lack of documentation related to how often the unit was used, as well as outcomes in terms of pain relief and function. There is lack of documentation related to physical therapy or medication having been tried and failed. In addition, there is a lack of documentation related to a treatment plan including the specific short and long term goals of treatment with the TENS unit. The request as submitted failed to provide frequency and specific site at which the interferential unit was to be utilized. Therefore, the request for interferential unit is not medically necessary.

**Heating pad:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 173-174, 182 and 300.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Low Back, Heat Therapy.

**Decision rationale:** The Official Disability Guidelines recommend a therapy as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain. One study compared the effectiveness of the Johnson and Johnson Back Plaster, The ABC Warme Pflaster and the Procter and Gamble ThermaCare Heat Wrap and concluded that the ThermaCare Heat Wrap is more effective than the other 2. Active warming reduces acute low back pain during moderate rescue transport. Combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared to other interventions alone. The clinical information provided for

review, lacks documentation utilizing a VAS pain scale to assess the injured worker's pain level. In addition, the request as submitted failed to provide for a specific site at which the heat pad was to be utilized as well as directions for use. Therefore, the request for heating pad is not medically necessary.

**X-ray of cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

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

**Decision rationale:** The California MTUS/ACOEM Guidelines state that the criteria for ordering imaging studies would include emergence of a red flag, physiological evidence of tissue insult or neurological dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. The clinical information provided for review indicates the injured worker has previously participated in physical therapy, failure of physical therapy was not provided within the documentation available for review. In addition, the clinical note dated 04/14/2014 indicates the patient underwent an x-ray of the cervical spine on that date, the results of which were not provided within the documentation. The rationale for the request of a second cervical spine x-ray was not provided within the documentation available for review. Therefore, the request for x-ray of the cervical spine is not medically necessary.

**X-ray of thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

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

**Decision rationale:** The California MTUS/ACOEM Guidelines state that the criteria for imaging studies ordering imaging studies would include emergence of a red flag, physiological evidence of tissue insult or neurological dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. The clinical information provided for review indicates the injured worker has previously participated in physical therapy, failure of physical therapy was not provided within the documentation available for review. In addition, the clinical note dated 04/14/2014 indicates the patient underwent an x-ray of the thoracic spine on that date, the results of which were not provided within the documentation. The rationale for the request of a second thoracic spine x-ray was not provided within the documentation available for review. Therefore, the request for x-ray of the thoracic spine is not medically necessary.

**X-ray of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

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

**Decision rationale:** The California MTUS/ACOEM Guidelines state that lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. The clinical note dated 04/14/2014 indicates the patient underwent a lumbar spine x-ray on that date. The results of which were not provided within the documentation available for review. The rationale for the request of a second x-ray of the lumbar spine was not provided within the documentation available for review. Therefore, the request for x-ray of the lumbar spine is not medically necessary.

**X-ray of right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

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

**Decision rationale:** The California MTUS/ACOEM Guidelines state that the primary criteria for ordering imaging studies would include emergency of a red flag, physiological evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to invasive procedure. The clinical information provided for review indicates the injured worker has previously participated in physical therapy, the results of which were not provided within the documentation. In addition, the clinical note dated 04/14/2014 indicates the patient had a right shoulder x-ray on that date. The results of which were not provided within the documentation. The rationale for request for the second x-ray of the right shoulder was not provided. Therefore, the request for x-ray of the right shoulder is not medically necessary.

**MRI of cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 172.

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

**Decision rationale:** The California MTUS/ACOEM Guidelines state that if physiological 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 for

neural or other soft tissue. The recent evidence indicates cervical disc annular tears may be missed on MRI. The clinical note dated 04/14/2014 indicates the patient underwent cervical spine x-ray on that date. The results of which were not provided within the documentation available for review. The clinical information lacks documentation of emergence of a red flag or neurological deficits. Pending the x-ray results, the request for an MRI of the cervical spine is not medically necessary.

**MRI of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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

**Decision rationale:** The California MTUS/ACOEM Guidelines state that if physiological evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define potential cause for neural or other soft tissue. There is lack of documentation related to the injured worker's physiological evidence of tissue insult or nerve impairment. The clinical note dated 04/14/2014 indicates the injured worker had an x-ray of the lumbar spine, the results of which were not provided within the documentation. The clinical information lacks documentation of emergence of a red flag or neurological deficits. Pending results from the x-ray, the request for MRI of the lumbar spine was not medically necessary.

**MRI of right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 202.

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

**Decision rationale:** The California MTUS/ACOEM Guidelines state that imaging may be considered for a patient whose limitations due to consistent symptoms have persisted for 1 month or more. When surgery is considered, which would include when surgery is being considered for specific anatomic defect. Magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impacting comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be at the preferred investigation because it demonstrates soft tissue anatomy better. The clinical information provided for review indicates the injured worker had a right shoulder x-ray on 04/14/2014; the results of which were not provided within the documentation. The clinical information lacks documentation of emergence of a red flag or neurological deficits. Pending results of the right shoulder x-ray, the request for MRI of the right shoulder is not medically necessary.