

<b>Case Number:</b>	CM15-0199230		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	08/12/2013
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	09/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Internal Medicine

### 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(n) 45 year old female, who sustained an industrial injury on 8-12-13. The injured worker was diagnosed as having cervicgia, lumbago and bilateral shoulder strain with impingement. Medical records (5-7-15 through 6-3-15) indicated 9-10 out of 10 pain in the neck, left arm, back and right leg. The physical exam (3-4-15 through 6-3-15) revealed tenderness and guarding in the cervical, thoracic and lumbar spine, intact sensation throughout the upper and lower extremities and decreased cervical and lumbar range of motion. As of the doctor's first report of injury dated 8-18-15, the injured worker reports pain in her bilateral shoulders, bilateral hands and wrist, neck and lower back. There is no physical examination. She rates her pain 8.5-10 out of 10. Treatment to date has included cervical x-rays on 3-4-15 showing severe disc space narrowing with osteophytosis, lumbar x-rays on 3-4-15 showing no sign of any significant pathology, Tramadol and Gabapentin. The treating physician requested physical therapy 2 x weekly for 4 weeks to the cervical spine, lumbar spine and bilateral upper extremities, a lumbar MRI, a cervical MRI, a bilateral shoulder MRI, a bilateral wrist MRI and bilateral wrist brace. The Utilization Review dated 9-24-15, non-certified the request for physical therapy 2 x weekly for 4 weeks to the cervical spine, lumbar spine and bilateral upper extremities, a lumbar MRI, a cervical MRI, a bilateral shoulder MRI, a bilateral wrist MRI and bilateral wrist brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 times a week for 4 weeks to Cervical Spine, Lumbar Spine, Bilateral Upper Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Chapter.

**Decision rationale:** MTUS states that 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. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency. When the treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. Documentation fails to show significant objective improvement in physical function with prior course of physical therapy and there is no evidence of exceptional factors noted. The medical necessity for additional active physical therapy has not been established. Per guidelines, the request for Physical Therapy 2 times a week for 4 weeks to Cervical Spine, Lumbar Spine, Bilateral Upper Extremities is not medically necessary.

**MRI Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** MTUS recommends Lumbar spine x rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Documentation fails to show objective clinical evidence of specific nerve compromise on physical examination or acute exacerbation of the injured worker's symptoms. The request for MRI study of lumbar spine is not medically necessary per MTUS guidelines.

**MRI Cervical Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** MTUS recommends spine x rays in patients with neck pain only when there is evidence of red flags for serious spinal pathology. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. Documentation fails to show objective clinical evidence of specific nerve compromise on the physical examination consistent with serious spinal pathology to establish the medical necessity for MRI. The request for MRI Cervical Spine is not medically necessary.

**MRI Bilateral Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

**Decision rationale:** MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker complains of chronic bilateral shoulder pain. Chart documentation fails to show any red flags or unexplained physical findings on examination to support the recommendation for MRI. The request for MRI Bilateral Shoulder is not medically necessary by MTUS.

**MRI Bilateral Wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand Chapter.

**Decision rationale:** MTUS and ODG recommend Magnetic resonance imaging (MRI) in the evaluation of chronic wrist pain only when plain films are normal and other conditions such as soft tissue tumors are suspected. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The injured worker complains of chronic bilateral wrist pain. At the time of the request under review, documentation failed to show objective clinical findings suspicious of

other more serious conditions to support the recommendation for MRI. The request for MRI Bilateral Wrist is not medically necessary by MTUS.

**Bilateral Wrist Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand Chapter, Splints.

**Decision rationale:** MTUS states that the initial treatment of Carpal Tunnel Syndrome (CTS) should include the use of night splints. Day splints can be considered for patient comfort as needed to reduce pain, along with work modifications. ODG recommends splints for treating displaced fractures. A small splint for pain relief during the day combined with a custom-made and rigid splint for prevention of deformities at night may be an optimal regimen. The injured worker has ongoing bilateral wrist pain. Documentation fails to demonstrate that the injured worker has a fracture, a diagnosis of Carpal Tunnel syndrome or acute exacerbation of symptoms to justify the recommendation for the use of wrist brace. The request for bilateral wrist brace is not medically necessary per guidelines.