

<b>Case Number:</b>	CM15-0020502		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	06/10/2013
<b>Decision Date:</b>	04/21/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 43 year old female, who sustained an industrial injury on June 10, 2013. The injured worker had reported neck, back and left shoulder injuries. The documentation notes the injured worker developed swelling and paresthesia in the left hand following the industrial injury. The diagnoses have included left carpal tunnel syndrome, left thumb stenosing tenosynovitis, shoulder and upper arm sprain/strain, brachial neuritis or radiculitis, lumbar radiculopathy and cervical radiculopathy. Treatment to date has included medications, physical therapy, night splints, cortisone injections, left carpal tunnel release and left thumb surgery. Current documentation dated December 1, 2014 notes that the injured worker complained of low back pain and left shoulder pain. The low back pain was noted to be sharp, burning and achy and radiated to the right hip, right thigh and right knee. There was tenderness to palpation of the cervical and shoulder muscles but no documentation of neurological tests. Physical examination of the lumbar spine revealed tenderness and a decreased range of motion. Straight leg raise was noted to be positive on the left side. Current requested treatments include physical therapy two times a week times six weeks to the low back and an MRI of the cervical spine. The medications listed are Tramadol, Neurontin and Protonix. A Utilization Review determination was rendered recommending non certification for Physical Therapy 2x6 for the low back and MRI Cervical Spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2x6 For The Low Back: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 22, 46-47, 96-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low and Upper Back Physical Therapy.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that physical therapy (PT) can be utilized for the treatment of low back pain when conservative treatments with medications and activity modification have failed. The records show that the patient completed supervised PT, and had progressed to a home exercise program as recommended by the guidelines. There is no documentation of exacerbation of the low back pain that would require another series of supervised PT. The criteria for PT 2 X 6 for Low Back was not met. Therefore, this is not medically necessary.

**MRI Cervical Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Neck and Upper Back.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that MRI can be utilized in the evaluation of the musculoskeletal pain in the presence of progressive neurological deficits or red flag condition when routine X-ray tests was inconclusive. The records did not show that a routine cervical spine clinical and X-ray tests was inconclusive. There was no documentation of subjective or objective findings of neurological deficits related to the cervical spine or the upper extremities. The criteria for MRI of the cervical spine was not met. Therefore, this is not medically necessary.