

Case Number:	CM15-0036633		
Date Assigned:	03/05/2015	Date of Injury:	05/07/2013
Decision Date:	11/02/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	02/26/2015

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: Anesthesiology

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 42-year-old male with an industrial injury dated 05-07-2013. A review of the medical records indicates that the injured worker is undergoing treatment for tenosynovitis hand and wrist bilateral, median neuritis, osteoarthritis not otherwise specified hand bilateral. Treatment consisted of MRI of right hand on 12-26-2014, MRI left shoulder on 12-23-2014, MRI right shoulder on 12-23-2014, MRI of lumbar spine on 12-23-2014, MRI of cervical spine on 12-23-2014, prescribed medications, and periodic follow up visits. In the most recent progress note dated 10-17-2014, the injured worker reported bilateral hand pain. The injured worker rated pain a 3 out of 10 at rest and a 5-6 out of 10 with use. Physical exam (10-17-2014) revealed tenderness to palpation over the greater thenar eminence on the left and bilateral hypertrophic changes of osteoarthritis affected the DIP and PIP joints of the bilateral fingers. Magnetic Resonance Imaging (MRI) of the right hand on 12-26-2014 revealed fusion of the proximal interphalangeal joint with mild bony deformities at the base of the middle phalanx and head of the proximal phalanx of the 3rd digit. MRI of the left shoulder on 12-23-2014 revealed hooked, laterally, and anteriorly down sloping acromion causing narrowing of the supraspinatus outlet which may predispose to impingement. MRI right shoulder on 12-23-2014 revealed cystic focus adjacent to the distal aspect of the infraspinatus tendon that may reflect a ganglion cyst. MRI of lumbar spine dated 12-23-2014 revealed straightening of the lumbar lordosis which may reflect an element of myospasms, early disc desiccation at L3-L4 down to L5-S1 with decreased disc height at L5-S1, annular fissure at L5-S1, L4-5 broad base disc herniation butting the thecal sac, and L5-S1 broad based disc herniation butting the thecal sac. The treating physician prescribed services for retrospective chiropractic therapy, 8 visits, chiropractic sessions two times a week for four weeks, acupuncture twice a week for four weeks, MRI and X-Ray for cervical spine,

lumbar spine, and bilateral shoulders, and X-ray of bilateral hands, and neurodiagnostic studies. The original utilization review (02-17-2015) denied the request for chiropractic therapy x 8 retro visits, chiropractic 2 x 4 weeks, acupuncture 2 x 4, MRI and X-Ray for cervical spine, lumbar spine, bilateral shoulders, X-ray bilateral hands, and neuro-diagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Chiropractic therapy, 8 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: According to MTUS, Manual Therapy or Chiropractic therapy is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the treatment of low back a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, the requested number of sessions exceeded the MTUS recommendation. Medical necessity for the requested services was not established. The requested services were not medically necessary.

Chiropractic two times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: According to MTUS, Manual Therapy or Chiropractic therapy is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the treatment of low back a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, there is no documentation of objective functional improvement, reduction of pain score, or a decrease in medication usage from previous chiropractic therapy. Medical necessity for the requested 8 additional chiropractic visits has not been established. The requested services are not medically necessary.

Acupuncture twice a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The California MTUS Acupuncture guidelines apply to all acupuncture requests, for all body parts and for all acute or chronic, painful conditions. According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, the requested acupuncture sessions (8) exceeds the guideline recommendations. Medical necessity of the requested acupuncture sessions has not been established. The requested services are not medically necessary.

MRI and X-Ray for Cervical Spine, Lumbar Spine, and bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Physical Examination, and Low Back Complaints 2004, Section(s): Physical Examination. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) X-rays / MRI studies.

Decision rationale: The CA MTUS ACOEM Guidelines indicate that if neck symptoms persist beyond four to six weeks, further evaluation may be indicated. The injured worker has been complaining of neck pain since his injury on 12-04-2013. The criteria for ordering imaging studies are: emergence of a red flag; physiologic evidence of tissue injury or trauma or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy before an invasive procedure. The guidelines also indicate that "cervical radiographs are most appropriate for patients with acute trauma associated with midline vertebral tenderness, head injury, drug or alcohol intoxication, or neurologic compromise. There was no specific indication for cervical spine films. Medical necessity for the requested x-ray studies was not established. The requested x-rays were not medically necessary. According to CA MTUS/ACOEM guidelines, a cervical MRI is indicated if unequivocal findings identify specific nerve compromise on the neurologic examination, in patients who do not respond to conservative treatment, and who would consider surgical intervention. Cervical MRI is the mainstay in the evaluation of myelopathy. Per ODG, MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the documentation indicates that the patient had a previous cervical MRI which did not reveal nerve impingement. There are no new neurologic findings on physical exam to warrant another MRI study. Medical necessity for the requested service is not established. The requested service is not medically necessary. Lumbar spine radiography 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. According to the American College of Radiology, "It is now clear from previous studies that uncomplicated acute low back pain is a benign, self-limited condition that does not warrant any

imaging studies." Indications for plain x-rays include, lumbar spine trauma with pain and tenderness, neurologic deficit, or chance of a fracture. In addition, x-rays are indicated for uncomplicated low back pain, steroids, osteoporosis, age over 70, suspicion of cancer or infection; myelopathy and post-surgery to evaluate the status of a fusion. In this case, there is no documentation of subjective complaints or objective physical exam findings for which x-rays of the lumbar spine would be medically necessary. The requested services are not medically necessary. According to California MTUS Guidelines, an MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for an MRI of the lumbar spine. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, there is no specific indication for a repeat MRI of the lumbar spine. Medical necessity for the requested MRI has not been established. The requested imaging is not medically necessary. X-rays of the shoulder are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when there is evidence on history and/or physical exam which raises suspicion of a serious shoulder condition. Cases of shoulder impingement are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen around the gleno-humeral or AC joint. Medical necessity for the requested item has not been established. The requested item is not medically necessary. According to the ODG, an MRI of the shoulder is indicated for the evaluation of acute shoulder trauma, suspected rotator cuff tear/impingement, in patients over age 40 with normal plain radiographs, subacute shoulder pain, and suspected instability/labral tear. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. There is no discussion of surgery or emergence of any red flag findings on exam to warrant another (second) MRI of the right shoulder. Medical necessity for the requested MRI has not been established. The requested study is not medically necessary.

X-ray of bilateral hands, Neurodiagnostic studies: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back; Forearm, Wrist and Hand.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiography of the hands, Nerve Conduction Testing.

Decision rationale: According to the ODG, most patients with known or suspected trauma of the hand, wrist, or both, the conventional radiographic survey provides adequate diagnostic information and guidance to the surgeon. However, in one large study, wrist fractures, especially those of the distal radius and scaphoid, accounted for more delayed diagnoses than any other traumatized region in patients with initial normal emergency room radiographs. Thus, when initial radiographs are equivocal, or in the presence of certain clinical or radiographic findings, further imaging is appropriate. In this case there is no specific indication for the requested hand films. Medical necessity for the requested studies is not established. The requested studies are not medically necessary. The request for diagnostic testing EMG/NCV for bilateral upper extremities is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The ODG further states that nerve conduction studies are recommended if the

EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. The electromyography testing has not been conducted to rule out radiculopathy prior to the request for the nerve conduction study. Given the above, the request for the diagnostic EMG/NCV of bilateral upper extremities is not medically necessary.