

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0046839 |                              |            |
| <b>Date Assigned:</b> | 03/19/2015   | <b>Date of Injury:</b>       | 04/01/2013 |
| <b>Decision Date:</b> | 05/01/2015   | <b>UR Denial Date:</b>       | 02/18/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/12/2015 |

### 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: California  
 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:

This 60 year old woman sustained an industrial injury on 4/1/2013. The mechanism of injury is not detailed. Diagnoses include cervicothoracic strain/arthrosis, left shoulder improved adhesive capsulitis, improved right shoulder impingement syndrome, bilateral carpal tunnel syndrome, lumbosacral strain/arthrosis, and sleep disturbance secondary to pain. Treatment has included oral medications, physical therapy, home exercise program, chiropractic treatment, and acupuncture. Physician notes on a PR-2 dated 2/6/2015 show complaints of increased neck and low back pain with increasing numbness and tingling in her hands. The worker is determined to be permanent and stationary. Recommendations include refills of medications, MRI of the cervical spine, consultation with a hand specialist, and physical therapy for the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Magnetic resonance imaging (MRI) of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 181-183.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses cervical spine MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) states that radiography are the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI may be recommended to evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. MRI may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. The primary treating physician's progress report dated 2/6/15 documented negative Spurling's and foraminal compression test on physical examination. Diagnoses included bilateral carpal tunnel syndrome and cervicothoracic strain. No rationale was given for the request for a cervical spine MRI. No cervical spine X-ray was documented. No acute cervical spine injuries were reported. Because red flags were not evidenced, the request for cervical spine magnetic resonance imaging is not supported. Therefore, the request for magnetic resonance imaging MRI of the cervical spine is not medically necessary.

**Physical therapy 2 times a week for 6 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. ODG Preface Physical Therapy Guidelines.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Official Disability Guidelines (ODG) present physical therapy PT guidelines. Patients should be formally assessed after a six-visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. The date of injury was 04-01-2013. Past treatments have included PT physical therapy, acupuncture, and chiropractic. The primary treating physician's progress report dated 2/6/15 documented a history of cervicothoracic strain, left shoulder adhesive capsulitis, right shoulder impingement syndrome, bilateral carpal tunnel syndrome, and lumbosacral strain. No functional improvement with past PT physical therapy was documented. Per ODG, patients should be formally assessed after a six visit clinical trial to evaluate whether

PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. The request for 12 sessions of PT physical therapy exceeds MTUS and ODG guidelines, and is not supported. Therefore, the request for 12 sessions of PT physical therapy is not medically necessary.