

<b>Case Number:</b>	CM15-0083237		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	01/19/2015
<b>Decision Date:</b>	09/10/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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 male, who sustained an industrial injury on 01/19/2015. He has reported subsequent neck, back, shoulder, and wrist, hand, knee and foot pain and was diagnosed with cervical, lumbar, bilateral shoulder, wrist, hand, knee and foot strain/sprain. Treatment to date has included oral pain medication, chiropractic therapy, physical therapy, massage, a home exercise program and traction. The 2/10/2015 X-ray reports of the cervical spine, lumbar spine and bilateral hips did not show any significant abnormality. On 1/28/2015, there were objective findings of T6 to T10 paraspinal muscle and trapezius tenderness. During an office visit dated 03/11/2015, a request for authorization of acupuncture, physical therapy and chiropractic manipulation X 2 /week for 4-6 weeks for the cervical spine, lumbar spine, shoulders, feet, hands and left wrist, MRI of the cervical spine, lumbar spine and left knee and x-ray of the left wrist were submitted. The visit note is illegible so the subjective and objective examination findings are unclear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture 2 times a week for 4-6 weeks for the cervical spine, lumbar spine, shoulders, feet, hands, and left wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that Acupuncture treatments can be utilized for the treatment of exacerbation of musculoskeletal pain. The beneficial effects of acupuncture treatment include pain relief, reduction of medications utilization and functional restoration. The records did not show detailed subjective or objective findings that is consistent with exacerbation of musculoskeletal pain. The records indicate that the patient had completed chiropractic evaluations and treatments. There is no documentation of functional restoration following prior medical treatments. The criteria for the Acupuncture treatments 2X per week for 4 to 6 weeks to the cervical spine, lumbar spine, shoulders, feet, hands and left wrist is not medically necessary.

**Chiropractic manipulation 1 time a week for 4-6 weeks for the cervical spine, lumbar spine, shoulders, feet, hands and left wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46-47, 96-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that chiropractic therapy can be utilized for the treatment of exacerbation of musculoskeletal pain. The beneficial effects of physical treatment include pain relief, reduction of medication utilization and functional restoration. The records did not show detailed subjective or objective findings that is consistent with exacerbation of musculoskeletal pain. The records indicate that the patient had completed chiropractic evaluations and treatments. There is no documentation of functional restoration following prior physical treatments. The guidelines recommend that patients proceed to a home exercise program after a supervised physical therapy. The criteria for the chiropractic therapy 1 X / week for 4 to 6 weeks to the cervical spine, lumbar spine, shoulders, feet, hands and left wrist is not medically necessary.

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-188. 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 tests can be utilized for further evaluation of worsening musculoskeletal pain when clinical evaluations and plain radiological tests are inconclusive. MRI was also noted to be useful to confirm clinical findings of neurological deficits or the presence of red flag condition. The available records did not show subjective, objective of plain radiological findings consistent with neurological deficits or a red flag condition related to the cervical spine. The criteria for MRI of the cervical spine were not medically necessary.

**MRI of the left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Knee.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that MRI tests can be utilized for further evaluation of worsening musculoskeletal pain when clinical evaluations and plain radiological tests are inconclusive. MRI was also noted to be useful to confirm clinical findings of neurological deficits or the presence of red flag condition. The available records did not show subjective, objective of plain radiological findings consistent with neurological deficits or a red flag condition related to the left knee. The criteria for MRI of the Left Knee were not medically necessary.

**MRI of the 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): 303-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low Back.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that MRI tests can be utilized for further evaluation of worsening musculoskeletal pain when clinical evaluations and plain radiological tests are inconclusive. MRI was also noted to be useful to confirm clinical findings of neurological deficits or the presence of red flag condition. The available records did not show subjective, objective of plain radiological findings consistent with neurological deficits or a red flag condition related to the lumbar spine. The criteria for MRI of the Lumbar spine were not medically necessary.

**Physical therapy 2 times a week for 4-6 weeks for the cervical spine, lumbar spine, shoulders, feet, hands, and left wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46-47, 96-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that physical therapy can be utilized for the treatment of exacerbation of musculoskeletal pain. The beneficial effects of physical treatment include pain relief, reduction of medication utilization and functional restoration. The records did not show detailed subjective or objective findings that is consistent with exacerbation of musculoskeletal pain. The records indicate that the patient had completed chiropractic evaluations and treatments. There is no documentation of functional restoration following prior physical treatments. The guidelines recommend that patients proceed to a home exercise program after a supervised physical therapy. The criteria for the physical therapy 2X/week for 4 to 6 weeks to the cervical spine, lumbar spine, shoulders, feet, hands and left wrist was not medically necessary.

**X-ray of the left wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Upper Extremity.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that radiological tests can be utilized for further evaluation of worsening musculoskeletal pain when clinical evaluations are inconclusive. Radiological tests were also noted to be useful to confirm clinical findings of neurological deficits or the presence of red flag condition. The available records did not show significant subjective or objective findings consistent with left wrist pathology or a red flag condition. The criteria for X-ray of the left wrist were not medically necessary.