MAXIMUS Federal Services

Case Number:	CM15-0085915		
Date Assigned:	05/08/2015	Date of Injury:	06/16/2014
Decision Date:	06/19/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/05/2015

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: North Carolina
Certification(s)/Specialty: Family Practice

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 06/16/2014. She experienced sharp pain in her arms and hands that progressively worsened. She was unable to use her feet to press on the pedals and frequently used bandages. The original injury was on 08/04/2011, but records submitted for review reflect another injury on 06/16/2014. Treatment to date has included x-rays, medications, electro diagnostic testing and physical therapy. According to a progress report dated 03/26/2015, the injured worker presented with neck, bilateral shoulder, bilateral wrist, back, right hip, leg, knee, and foot complaints. She was relatively unchanged since her last visit. She had been recently authorized for updated MRIs of her bilateral shoulders and 4 sessions of physical therapy for her shoulders. In regards to medications, she was taking none. She had not tried Advil, Aleve or Tylenol. She had been prescribed Tylenol #3 and Pamelor but did not take them due to liver issues. She was using topical LidoPro cream with some relief. She last worked in June 2014 due to no modified work being available. The injured worker complained of constant stabbing pain that went out over her shoulders and into her right upper back. She currently rated her pain 6 on a scale of 1-10. She had constant stabbing pain with tingling on the top of the hand near the fifth finger. Pain radiated up to her forearms at times. Pain was rated 6. She had constant stabbing pain in her right low back/right hip. Pain radiated down her right lower extremity to the ankle level. Low back pain was rated 6 and right ankle pain was rated 4. Electro diagnostic testing of the bilateral upper extremities performed on 02/23/2015 demonstrated a normal exam. Electro diagnostic testing of the bilateral lower

extremities performed on 03/04/2015 demonstrated evidence of right S1 radiculopathy and no electro diagnostic evidence of generalized peripheral neuropathy affecting the lower limb. Diagnoses included rule out cervical, thoracic and lumbar herniated nucleus pulposus and cervical and lumbar radiculopathy. Treatment plan included MRI of the cervical and lumbar spine, ongoing podiatry follow ups, ongoing general orthopedic follow ups, a trial of chiropractic rehabilitative care for the cervical, thoracic and lumbar spine, Tramadol, LidoPro cream and a trial of Ketoprofen cream. Currently under review is the request for an MRI of the cervical and lumbar spine, a trial of chiropractic rehabilitative therapy for the cervical/thoracic and lumbar spine 2 times per week for 4 weeks and a follow up consultation in 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) of the Cervical Spine and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back MRI (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.

Trial of Chiropractic Rehabilitative Therapy for the Cervical/Thoracic and Lumbar Spine, 2 times per wk for 4 wks (8 sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual manipulation Page(s): 58-59.

Decision rationale: The California chronic pain medical guidelines section on manual manipulation states: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care & Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/ maintenance care & Not medically necessary. Recurrences/flare-ups & Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines. a. Time to produce effect: 4 to 6 treatments. Manual manipulation is recommended form of treatment for chronic pain. However, the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request is for 8 sessions. This does not meet criteria guidelines and thus is not medically necessary.

Follow Up consultation in 6 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain chapter Office visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, reevaluation.

Decision rationale: The California MTUS and ACOEM do not directly address the requested service. The ODG states follow up visits are based on medical necessity as evidenced by ongoing symptoms and response to therapy. The patient meets criteria for a follow up consultation and therefore the request is medically necessary.