

<b>Case Number:</b>	CM14-0147177		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	09/20/2012
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	08/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 records presented for review indicate that this 37 year-old female was reportedly injured on 9/20/2012. The mechanism of injury is noted as a lifting injury. The most recent progress notes dated 8/13/2014 and 8/21/2014, indicate that there are ongoing complaints of neck, mid back and low back pain. Physical examination demonstrated tenderness to cervical spine with bilateral spasm; decreased sensation to light touch C5-C6 on right; motor 4+/5 strength shoulder abduction, elbow flexion/extension, and wrist flexion/extension on right; decreased cervical spine range motion; positive Spurling's on the right; positive Roos on right; positive tenderness to thoracic/lumbar spine and SI joints; decreased sensation to light touch L3-L5 on right; negative straight leg raise; positive hamstring contracture bilaterally; no motor deficits with hip flexion, knee flexion/extension, and ankle flexion/extension; limited lumbar range of motion secondary to pain. No recent diagnostic imaging studies of the lumbar spine available for review. Previous treatment includes physical therapy, traction, TENS unit and medications. A request had been made for MRI lumbar spine and chiropractic treatment #12 sessions for the spine and right shoulder, which were not certified in the utilization review on 8/20/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation ODG treatment guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, MRIs (magnetic resonance imaging)

**Decision rationale:** The request for MRI lumbar spine is not medically necessary. The previous request was denied on the basis that it was not clear that there has been any treatment directed at the low back. There were no red flags. There was no indication that the injured worker is a surgical candidate; therefore, guidelines would not support MRI of the low back given this presentation. There was no report of a new acute injury. There were no physical examination findings of any decreased motor strength, increased reflex or sensory deficits. There were no focal neurological deficits. There was no indication that plain radiographs were obtained prior to the request for more advanced MRI. There was no mention that a surgical intervention is anticipated. Given this, the request for MRI of the lumbar spine is not indicated as medically necessary.

**Chiropractic treatment x12 sessions for the spine and right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** The request for chiropractic treatment x 12 sessions for the spine and right shoulder is not medically necessary. The previous request was denied on the basis that it does not appear that the injured worker has received any chiropractic treatment for the neck or back previously; however, current evidence based guidelines recommend an initial regimen of 6 visits. Therefore, those are not approved. However, there was no support in the guidelines for treatment of the shoulders and additionally, the requesting report does not contain any diagnosis related to the shoulder or any specific examination of the shoulder; therefore, there is no establishment of any shoulder pathology to be addressed and the request is not indicated as medically necessary. The CAMTUS recommends a trial of 6 visits over 2 weeks for the low back, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks may be authorized. There was no additional significant objective clinical information provided that would support the need to exceed the CAMTUS recommendations, either in frequency or duration of chiropractic manipulation visits. Given this, the request for chiropractic treatment x 12 visits for the spine and right shoulder is not indicated as medically necessary.