

<b>Case Number:</b>	CM14-0092424		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	04/04/2011
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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:

This is a patient with a date of injury of 4/4/11. A utilization review determination dated 5/19/14 recommends non-certification of upright MRI of the cervical and thoracic spine, x-rays of the thoracic, cervical, and right shoulder, and MRI of the right shoulder. Chiropractic treatments and work conditioning was modified from 21 sessions to 6 chiropractic sessions. 23 acupuncture sessions were modified to certify 6 sessions. It referenced a 5/23/11 chiropractic report identifying right neck pain radiating to the shoulder and shoulder blade. On exam, there was tenderness, decreased cervical and thoracic range of motion (ROM), muscle spasm, and swelling. Anterior and posterior apprehension testing was positive on the right and cervical compression and distraction testing was positive bilaterally.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **21 Chiro Treatments and Work Conditioning between 5/2/2011 and 8/31/2011: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60,125-126. Decision based on Non-MTUS Citation Official Disability Guidelines: Physical Medicine

**Decision rationale:** Regarding the request for 21 Chiropractic treatments and work conditioning, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Specific to work conditioning, up to 10 sessions are supported by the CA MTUS and ODG, and ODG specifically notes that it amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision. Within the documentation available for review, while there may be an indication for an initial trial of 6 chiropractic sessions as recommended by the previous utilization reviewer, there is no clear indication for the 21 sessions of chiropractic treatment and/or work conditioning, and unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested 21 Chiropractic treatments and work conditioning are not medically necessary.

### **23 Acupuncture Sessions between 5/24/2011 and 5/24/2011: Upheld**

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

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

**Decision rationale:** Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "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." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, while there may be an indication for an initial trial of 6 sessions as recommended by the previous utilization reviewer, the current request for a visit exceeds the 6-visit trial recommended by guidelines. Unfortunately, there is no provision to modify the current request. In light of the above issues, the currently requested acupuncture is not medically necessary.

### **1 Upright MRI of the Thoracic Spine 5/24/2011: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177.

**Decision rationale:** Regarding the request for thoracic MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of

the anatomy prior to an invasive procedure. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally, there is no documentation of neurologic deficit or failure of conservative treatment (which was also recommended by the provider and some of which was authorized). In the absence of such documentation, the requested thoracic MRI is not medically necessary.

**MRI of the Right Shoulder 5/24/2011: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** Regarding the request for MRI of the right shoulder, CA MTUS and ACOEM state that more specialized image studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Within the documentation available for review, there was no documentation of any red flags and failure of initial conservative management (some of which was authorized). In light of the above issues, the currently requested right shoulder MRI is not medically necessary.

**1 Upright MRI Cervical Spine, 5/24/2011: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177.

**Decision rationale:** Regarding the request for cervical MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally, there is no documentation of neurologic deficit or failure of conservative treatment (which was also recommended by the provider and some of which was authorized). In the absence of such documentation, the requested cervical MRI is not medically necessary.

**X-Ray of the Thoracic, Cervical, Right Shoulder, 5/2/2011: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**Decision rationale:** Regarding the request for x-rays of the thoracic, cervical, and right shoulder, the CA MTUS and ACOEM state that, with regard to imaging of the neck and upper back, x-rays are not recommended in the absence of red flags for serious spinal pathology even if the pain has persisted for at least 6 weeks. Regarding the shoulder, CA MTUS and ACOEM note that routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Red flags include evidence of fractures, dislocation, infection, tumor, progressive neurologic and/or vascular compromise, cardiac condition, sub-diaphragmatic conditions, and acute rotator cuff tear in a young worker. Routine radiographs for shoulder complaints before 4 to 6 weeks of conservative treatment are not recommended. Within the documentation available for review, there is no documentation of red flags or another clear rationale for x-rays in the absence of significant trauma. Additionally, there is no documentation of failure of conservative treatment (which was also recommended by the provider and some of which was authorized). In the absence of such documentation, the currently requested x-rays of the thoracic, cervical, and right shoulder are not medically necessary.