

<b>Case Number:</b>	CM15-0012382		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	03/25/2014
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: Physical Medicine & Rehabilitation

### 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 57-year-old female, with a reported date of injury of 03/25/2014. The diagnoses include cervical and lumbar spine sprain/strain, status post left knee arthroscopy with medial/lateral meniscectomy, and cervical spine pain. Treatments have included chiropractic treatments, physical therapy for the right shoulder, acupuncture, and Ibuprofen. The progress report dated 12/15/2014 indicates that the injured worker complained of low back pain that radiates to the lefts, left greater than right. She had a cramping sensation in the left calf, and pain with motion. The injured worker also had right shoulder pain with certain motions, and neck pain. She has done home stretches for the lumbar spine. The objective findings included right shoulder tenderness, and slightly limited range of motion. An examination of the lumbar spine showed positive left straight leg raise test. An examination of the neck showed positive spasm, and decreased range of motion. The treating physician requested twelve (12) chiropractic visits for the cervical and lumbar spine, orthotics to improve stand/walk tolerance, affected by knee and lumbar condition, x-ray of the cervical spine, and MRI of the cervical spine to evaluate persistent pain complaints, some hyperflexion, and weakness of right triceps muscle. On 12/30/2014, Utilization Review (UR) denied the request for chiropractic treatments three times a week for four weeks for the cervical and lumbar spines, purchase of bilateral foot orthotics, an x-ray of the cervical spine, and an MRI of the cervical spine. The UR physician noted no documentation to establish the medical necessity for the additional twelve visits of chiropractic care, no documentation to support the use of foot orthotics, no documentation describing red flag conditions indicating the medical necessity for x-rays, and no red flags diagnoses or exam

findings demonstrating physiologic evidence of neurologic findings on physical examination. The MTUS ACOEM Guidelines and Non-MTUS Official Disability Guidelines were cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Chiropractic treatment, 3 times a week, cervical & lumbar spine, per 12/16/2014 form qty: 12:** Overturned

**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 Therapy and Manipulation Page(s): 58-59.

**Decision rationale:** This patient presents with low back pain that radiates into the legs, right shoulder and neck pain. The current request is for CHIROPRACTIC TREATMENT, 3 TIMES A WEEK CERVICAL AND LUMBAR SPINE, PER 12/16/14 FORM QTY: 12. The utilization review denied the request stating that there is absent documentation to establish medical necessity. MTUS Manual Therapy and Manipulation guidelines pages 58, 59 state that treatment is recommended for chronic pain if caused by musculoskeletal conditions. MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For manual therapy, the MTUS guidelines on page 59 states, "Delphi recommendations in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24)." As stated in progress report dated 12/15/14, the patient is participating in physical therapy and acupuncture. The treating physician recommended 12 chiropractic treatments as well. The medical file provided for review does not discuss prior chiropractic treatments; therefore, this appears to be an initial request. Given the patients continued complaints and objective findings, the requested chiropractic treatment IS medically necessary.

**Purchase of bilateral foot orthotics, per 12/16/2014:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot (updated 12/22/14), Orthotic devices

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Ankle and foot chapter, Orthotics devices

**Decision rationale:** This patient presents with low back pain that radiates into the legs, right shoulder and neck pain. The current request is for PURCHASE OF BILATERAL FOOT ORTHOTICS, PER 12/16/14. The treating physician states that the orthotics is necessary to improve stand/walk tolerance. The MTUS and ACOEM Guidelines do not address this request; however, ODG Guidelines under ankle and foot chapter regarding orthotic devices states that it is recommended for plantar fasciitis and forefoot pain in rheumatoid arthritis. ODG also states,

both prefabricated and custom orthotic devices are recommended for plantar heel pain (plantar fasciitis, plantar fasciosis, heel-spur syndrome). Orthosis should be cautiously prescribed in treating plantar heel pain for those patients who stand for long periods; stretching exercises and heel pads are associated with better outcomes than custom-made Orthosis in people who stand for more than eight hours per day. The patient does not have a diagnosis of plantar fasciitis, but foot pain affected by knee and lumbar condition. In this case, the patient does not meet the required criteria by ODG for orthotic. The request IS NOT medically necessary.

**X-rays of cervical spine, per 12/16/2014 form: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG Neck & Upper Back (updated 11/18/14), Radiography (x-rays)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** This patient presents with low back pain that radiates into the legs, right shoulder and neck pain. The current request is for X-RAYS OF CERVICAL SPINE, PER 12/16/14 FORM. The Utilization review denied the request stating that there was no red flags conditions on examination.ACOEM guidelines on special studies for C-spine Chapter 8, page 177 and 178 states that the radiography is recommended for emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. For radiography for low back, ACOEM ch12, low back, pages 303-305: Special Studies and Diagnostic and Treatment Considerations Lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks.The treating physician states that X-ray and MRI are necessary to evaluate persistent pain complaints. This patient complains of neck pain with a date of injury from 3/25/14, and a review of the available progress reports does not indicate prior x-ray of the cervical spine. As per progress report dated 12/15/14, the patient has neck pain and examination findings revealed positive spasm, decrease in ROM and negative Spurling's test. In this case, the treating physician does not mention any potentially serious underlying conditions such as fracture, neurologic deficit, cancer, infection or tumor as indicated per ODG guidelines for an x-ray of the cervical spine. This request IS NOT medically necessary.

**MRI of the cervical spine, per 12/16/2014 form: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG Neck & Upper Back (11/18/14) Magnetic resonance imaging (MRI)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official disability guidelines Neck and back chapter, MRI

**Decision rationale:** This patient presents with low back pain that radiates into the legs, right shoulder and neck pain. The current request is for MRI OF THE CERVICAL SPINE, PER 12/16/14 FORM. The treating physician states that X-ray and MRI are necessary to evaluate persistent pain complaints. The Utilization review denied the request stating that there was no red flags conditions on examination. ACOEM Guidelines, chapter 8, page 177 and 178, state 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. ODG Guidelines, chapter Neck and Upper Back (Acute & Chronic) and topic Magnetic resonance imaging (MRI), have the following criteria for cervical MRI: (1) Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present (2) Neck pain with radiculopathy if severe or progressive neurologic deficit (3) Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present (4) Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present (5) Chronic neck pain, radiographs show bone or disc margin destruction (6) Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal" (7) Known cervical spine trauma: equivocal or positive plain films with neurological deficit (8) Upper back/thoracic spine trauma with neurological deficit. In this case, the patient complains of neck pain with a date of injury from 3/25/14, and a review of the available progress reports does not indicate prior MRI of the cervical spine. As per progress report dated 12/15/14, the patient has neck pain and examination findings revealed positive spasm, decrease in ROM and negative Spurling's test. ODG and ACOEM guidelines allow MRI only when significant neurologic deficit is suspected. Given the lack of clinical evidence, this request IS NOT medically necessary.