

<b>Case Number:</b>	CM15-0125976		
<b>Date Assigned:</b>	07/10/2015	<b>Date of Injury:</b>	10/13/2014
<b>Decision Date:</b>	09/15/2015	<b>UR Denial Date:</b>	06/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

### 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 63-year-old female, with a reported date of injury of 10/13/2014. The mechanism of injury was a slip and fall on a powdery substance on the floor. The injured worker's symptoms at the time of the injury included a left forearm fracture. The diagnoses include left distal radius fracture, left hand sprain/contusion, left shoulder and elbow contusion and sprain, left forearm contusion and sprain, neck sprain, and thoracic spine sprain. Treatments and evaluation to date have included physical therapy for the left wrist, and oral medications. The diagnostic studies to date have included x-rays of the left shoulder, left humerus, left elbow, left forearm, left wrist, and left hand which showed no changes. The progress report dated 05/08/2015 indicates that the injured worker stated that her left hand was flared-up because of colder weather. The pain radiated to her shoulder and back with activities. It was noted that therapy would be helpful. The x-rays of the left shoulder, left humerus, left elbow, left forearm, left wrist, and left hand showed no acute changes. The objective findings included tenderness of the left hand at the TFCC (triangular fibrocartilage complex), left shoulder abduction at 120 degrees, tenderness of the subacromial bursa, tenderness of the L5-S1 paraspinal muscles, and painful left impingement arc test. The injured worker was advised to remain off work until an unknown date. The treating physician requested physical therapy or chiropractic therapy, three times a week for six weeks; an MRI of the left shoulder; an MRI of the bilateral hips and pelvis; an MRI of the lumbar spine; a CT scan of the lumbar spine; and Voltaren 25mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy or chiropractic therapy three times a week for six weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine and Manual Therapy & Manipulation Page(s): 98-99 and 58-59.

**Decision rationale:** The CA MTUS Chronic Pain Guidelines recommend passive and active therapy. Passive therapy can provide short-term relief during the early phases of pain treatment; control symptoms of pain, inflammation, and swelling; and help improve the rate of healing soft tissue injuries. Active therapy is beneficial for restoring flexibility, strength, endurance, function, range of motion, and can relieve discomfort. The guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. For myalgia and myositis, 9-10 visits over 8 weeks are recommended; for neuralgia, neuritis, and radiculitis, 8-10 visits over 4 weeks are recommended; and for reflex sympathetic dystrophy (CRPS), 24 visits over 16 weeks are recommended. There was no evidence that the injured worker had been diagnosed with any of these conditions. The MTUS recommends manual therapy and manipulation for chronic pain if it's caused by musculoskeletal conditions. "The intended goal or effect of manual medicine is the achievement of positive symptomatic gains or objective measurable gains in functional improvement." Manual therapy and manipulation for the low back is recommended as an option; for the ankle and foot it is not recommended; for carpal tunnel syndrome it is not recommended; for the forearm, wrist, and hand it is not recommended; and for the knee it is not recommended. The treating physician's request did not include the specific body part or area for the physical therapy or chiropractic treatment. As such, the request is not sufficient. Therefore, the request for eighteen (18) physical therapy or chiropractic treatment sessions is not medically necessary.

**MRI of the left shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 202, 207-208.

**Decision rationale:** The CA MTUS ACOEM Guidelines indicate that "for most patients with shoulder problems, special studies are not needed unless a four to six week period of conservative care and observation fails to improve symptoms. There was no documentation that conservative care has been tried and failed to improve the injured worker's left shoulder symptoms. Most patients improve quickly, provided red-flag conditions are ruled out." The guidelines state that the primary criteria for ordering imaging studies are: emergence of a red flag; 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. The MTUS also states that "relying on imaging studies to evaluate the source of shoulder symptoms carries a significant risk of diagnostic confusion (false-positive test results)." There was documentation that the MRI of the left shoulder was ordered to rule out internal derangement. The request does not meet guideline criteria. Therefore, the request for an MRI of the left shoulder is not medically necessary.

#### **MRI of bilateral hips and pelvis: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional MRI, Pain Chapter, Hip and Pelvis.

**Decision rationale:** The MTUS does not address an MRI of the hips and pelvis. The non-MTUS Official Disability Guidelines indicate that an MRI is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. MRI is both highly sensitive and specific for the detection of many abnormalities involving the hip or surrounding soft tissues and should in general be the first imaging technique employed following plain films. Indications for MRI of the hips and pelvis include: osseous, articular or soft-tissue abnormalities; osteonecrosis; occult acute and stress fracture; acute and chronic soft-tissue injuries; and tumors. The treating physician requested an MRI of the bilateral hips and pelvis to rule out avascular necrosis. However, there was no documentation of the objective findings regarding the injured worker's bilateral hips and pelvis. The request is not sufficient. Therefore, the request for an MRI of the bilateral hips and pelvis is not medically necessary.

#### **MRI of the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** The CA MTUS ACOEM Guidelines indicate that if physiologic evidence shows tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause, such as an MRI for neural or other soft tissue, and CT scan for bony structures. The non-MTUS Official Disability Guidelines indicate that MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy. There was no evidence that he injured worker had prior low back surgery or a diagnosis of radiculopathy. The guidelines also indicate that they are not recommended until after at least one month conservative therapy, sooner if there is severe or progressive neurologic deficit. A repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology, such as a tumor, infection, fracture, neurocompression, or recurrent disc herniation.

There is no documentation that the injured worker had a prior MRI of the lumbar spine. The indications for MRIs of the low back include: Lumbar spine trauma (trauma, neurological deficit); Lumbar spine trauma (seat belt (chance), fracture (If focal, radicular findings or other neurologic deficit); suspicion of cancer, infection, other "red flags"; low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit; prior lumbar surgery; and cauda equina syndrome. The documentation did not include these conditions as recommended by the guidelines. The treating physician requested an MRI of the lumbar spine to rule out herniated nucleus pulposus. The request does not meet guideline recommendations. Therefore, the request for an MRI of the lumbar spine is not medically necessary.

**CT of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, CT (computed tomography).

**Decision rationale:** The CA MTUS ACOEM Guidelines indicate that if physiologic evidence shows tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause, such as an MRI for neural or other soft tissue, and CT scan for bony structures. The non-MTUS Official Disability Guidelines indicate that a CT scan of the low back is not recommended except for the following indications: lumbar spine trauma, neurological deficit, and seat belt (chance) fracture. The treating physician requested a CT scan of the lumbar spine to rule out herniated nucleus pulposus. The request does not meet guideline criteria. Therefore, the request for a CT scan of the lumbar spine is not medically necessary.

**Voltaren 25mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 22 and 67-68.

**Decision rationale:** The CA MTUS Chronic Pain Guidelines indicate that NSAIDs (non-steroidal anti-inflammatory drugs) is "recommended at the lowest dose for the shortest period in patients with moderate to severe pain." Voltaren (Diclofenac) is an NSAID. For back pain, NSAIDs are recommended as a second-line treatment after acetaminophen. MTUS states that anti-inflammatory medications are the traditional first line of treatment to reduce pain so that activity and function restoration can resume. However, long-term use may not be justified. There was documentation that Voltaren has been requested since at least 03/25/2015. There is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. The requested prescription is for an unstated quantity,

and the medical records do not clearly establish the quantity. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. Therefore, the request for Voltaren is not medically necessary.