

<b>Case Number:</b>	CM15-0072681		
<b>Date Assigned:</b>	04/22/2015	<b>Date of Injury:</b>	06/22/2014
<b>Decision Date:</b>	05/26/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2015

### 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: Pennsylvania

Certification(s)/Specialty: 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:

This 53 year old man sustained an industrial injury on 6/22/2014. Diagnoses include rule out cervical disc protrusion, rule out cervical radiculitis versus radiculopathy, thoracic spine strain/sprain, rule out lumbar disc protrusion, rule out lumbar radiculitis versus radiculopathy, right sacroiliac joint sprain, rule out knee meniscus tear, and depression. Treatment has included medications. Physician notes dated 2/10/15 and 3/17/2015 show complaints of cervical, thoracic, and lumbar spine, right hip and knee pain as well as depression. The injured worker reported frequent moderate neck pain radiating to both arms with numbness and tingling, constant severe low back pain with tingling and weakness, and constant moderate right hip and knee pain with weakness. Examination showed decreased and painful cervical range of motion with tenderness and spasm of the cervical paravertebral muscles, decreased and painful range of motion of the thoracic spine with tenderness of the spinous processes and paravertebral muscles and paravertebral muscle spasm, tenderness and spasm of lumbar paravertebral muscles with bilateral positive straight leg raise, tenderness of the SI joint with positive Patricks/Fabere's tests, no swelling of the right knee with decreased and painful range of motion, tenderness of the posterior knee, and positive McMurray's. Recommendations include consultation with neurosurgery, consultation with orthopedic surgery, consultation with pain management, acupuncture, chiropractic treatment, and physiotherapy. Work status was noted as temporarily totally disabled/off work. No imaging studies or electrodiagnostic testing were submitted. On 4/7/15, Utilization Review (UR) non-certified requests for physiotherapy 1 x 6 for lumbar spine and right knee, referral to neurosurgeon, chiropractic treatment 2 x 6 for lumbar spine and right knee,

referral to orthopedic surgeon, referral to pain management, and acupuncture 2 x 6 for lumbar spine and right knee, citing the MTUS, ACOEM, and ODG guidelines.

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

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

#### **Physiotherapy 1x 6 for Lumbar Spine and Right Knee: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: physical medicine treatment.

**Decision rationale:** Physical medicine is recommended by the MTUS with a focus on active treatment modalities to restore flexibility, strength, endurance, function, and range of motion, and to alleviate discomfort. The ODG states that patients should be formally assessed after a six visit clinical trial to evaluate whether physical therapy has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. Both the MTUS and ODG note that the maximum number of sessions for unspecified myalgia and myositis is 9-10 visits over 8 weeks, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. The records do not contain a sufficient prescription from the treating physician, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. Reliance on passive care is not recommended. The physical medication prescription is not sufficiently specific, and does not adequately focus on functional improvement. No functional goals were discussed. Per the MTUS chronic pain section, functional improvement is the goal rather than the elimination of pain. Due to lack of sufficiently specific prescription, the request for physical therapy is not medically necessary.

#### **Refer to Neurosurgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM: Independent Medical Examinations and Consultations.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): chapter 8. p. 179-181, chapter 12 p.305-307.

**Decision rationale:** This injured worker has chronic neck and back pain. The documentation indicates a request for consultation with a neurosurgeon for the cervical spine, thoracic spine, and lumbar spine. No imaging studies or electrodiagnostic testing were submitted. The ACOEM neck and upper back chapter states that referral for surgical consultation is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms, activity limitation for more than one month or with extreme progression of symptoms, clear clinical, imaging, and

electrophysiologic evidence consistently indicating the same lesion that has been shown to benefit from surgical repair, and unresolved radicular symptoms after receiving conservative treatment. The ACOEM low back chapter states that referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. In this case there were no physical examination findings, imaging studies, or electrodiagnostics consistent with radiculopathy. There are insufficient clinical findings of radiculopathy, such as dermatomal sensory loss or motor deficits correlating with a specific lesion identified by objective testing. Due to lack of specific indication, the request for referral to a neurosurgeon is not medically necessary.

**Chiropractic treatment 2 x 6 for Lumbar Spine and Right Knee: 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 and manipulation Page(s): 58-60.

**Decision rationale:** Per the MTUS for Chronic Pain, the purpose of manual medicine is functional improvement, progression in a therapeutic exercise program, and return to productive activities (including work). Per the MTUS for Chronic Pain, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. Per the MTUS, chiropractic manipulation is not recommended for the Ankle & Foot, Carpal tunnel syndrome, Forearm, Wrist, & Hand, Knee. The request includes chiropractic treatment for the knee, which is not recommended by the guidelines. The number of sessions requested (12) is in excess of the number of sessions recommended as an initial trial (6). Due to number of sessions requested in excess of the guidelines, and request for treatment of a body part that is not recommended by the guidelines, the request for Chiropractic treatment 2 x 6 for Lumbar Spine and Right Knee is not medically necessary.

**Refer to Orthopedic Surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM: Independent Medical Examinations and Consultations Chapter 7, page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) hip/pelvis chapter: office visits.

**Decision rationale:** This injured worker has chronic hip and knee pain. The documentation indicates a request for referral to an orthopedic surgeon for the right hip and right knee. The ACOEM states that referral for surgical consultation may be indicated for patients who have activity limitation for more than one month, and failure of exercise programs to increase range of motion and strength of the musculature around the knee. The ODG notes that office visits are recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. In this case, there was no documentation of activity limitation for more than one month or failure of an exercise program. Consideration of specific orthopedic surgical intervention was not discussed. No imaging studies were submitted. Due to lack of specific indication, the request for referral to an orthopedic surgeon is not medically necessary.

**Refer to Pain Management:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-311. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: office visits.

**Decision rationale:** This injured worker has chronic neck and back pain. The documentation indicates a request for pain management referral for the cervical and lumbar spine. The ODG notes that office visits are recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The treating physician progress notes did not provide an adequate history of the prior treatment for chronic pain with the outcomes of specific modalities. The reason for the request for pain management consultation was not documented, nor was there clear documentation of provider expectations from a pain management consultation. There was no documentation of a plan for epidural steroid injections. There is no documentation of intent for treatment that is outside of the scope of routine treatment provided by the primary treating physician. The request for pain management consultation is not medically necessary.

**Acupuncture 2 x 6 for Lumbar Spine and Right Knee:** Upheld

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

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

**Decision rationale:** Per the MTUS, acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The MTUS recommends an initial trial of 3-6 visits of

acupuncture. Frequency of treatment of 1-3 times per week with an optimum duration of 1-2 months is specified by the MTUS. Medical necessity for any further acupuncture is considered in light of functional improvement. Acupuncture treatments may be extended if functional improvement is documented. In this case, the injured worker was noted to have chronic back and knee pain. There was no documentation of intolerance to, or reduction of pain medication. There was no documentation of participation in physical rehabilitation or plan for surgery. The number of visits requested (12) is in excess of the maximum number recommended by the guidelines for an initial trial (6). Due to lack of indication in accordance with the guidelines and number of sessions requested in excess of the guidelines, the request for acupuncture is not medically necessary.