

<b>Case Number:</b>	CM15-0087679		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	02/06/2015
<b>Decision Date:</b>	10/02/2015	<b>UR Denial Date:</b>	04/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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 Jersey

Certification(s)/Specialty: Family Practice

### 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 35 year old male, who sustained an industrial injury on 2/6/2015. He reported a twisting injury. The injured worker was diagnosed as having lumbar sprain/strain, radicular neuralgia of left leg, cervical sprain/strain, thoracic sprain/strain, left shoulder sprain/strain and skin irritation on head. Treatment to date has included medications, ice. The request is for chiropractic therapy, acupuncture, magnetic resonance imaging of the left shoulder, magnetic resonance imaging of the lumbar spine, magnetic resonance imaging of the cervical spine, and a sleep study. On 2/17/2015, he complained of constant low back pain rated 8/10, left leg pain, left shoulder pain rated 7/10 and was intermittent, neck pain rated 9/10, left wrist pain rated 7/10, and mid-upper back pain rated 8/10. He was noted to have positive Kemp's, Valsalva, Milgram's, and straight leg raise testing. On 3/24/2015, he was reported to have had therapy and gotten better. He reported having left shoulder pain again approximately 4 months prior to this date. Currently he has low back pain rated 5/10, left leg pain rated 4/10, left shoulder pain rated 4/10, neck pain rated 5/10, and mid-upper back pain rated 4/10. The treatment plan included: continuing chiropractic treatment, acupuncture, magnetic resonance imaging of the left shoulder lumbar spine and cervical spine, sleep study, pain management consultation, and psyche evaluation. The records are unclear regarding functional improvement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **Chiropractic therapy 2 x 3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 61-62.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, pp. 58-60.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines state that for musculoskeletal conditions, manual therapy & manipulation is an option to use for therapeutic care within the limits of a suggested 6 visits over 2 weeks, with evidence of objective functional improvement, and a total of up to 18 visits over 6-8 weeks. It may be considered to include an additional 6 session (beyond the 18) in cases that show continual improvement for a maximum of 24 total sessions. The MTUS Guidelines also suggest that for recurrences or flare-ups of pain after a trial of manual therapy was successfully used, there is a need to re-evaluate treatment success, and if the worker is able to return to work then 1-2 visits every 4-6 months is warranted. Manual therapy & manipulation is recommended for neck and back pain, but is not recommended for the ankle, foot, forearm, wrist, hand, knee, or for carpal tunnel syndrome. In the case of this worker, reports suggested at least 12 completed chiropractic office visits with manipulation, however, it is not known which body areas were treated. Also, there was no report found in the notes to state significant functional gains and pain reduction with these previous sessions. Therefore, due to do evidence for long-term benefit and no specifics as to which body areas intended to treat (some are not recommended according to Guidelines), this request for chiropractic therapy will be considered medically unnecessary.

### **Acupuncture 2 x 3: Upheld**

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

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

**Decision rationale:** The MTUS Acupuncture Guidelines state acupuncture may be used as an adjunct therapy modality to physical rehabilitation or surgical intervention to hasten recovery and to reduce pain, inflammation, increase blood flow, increase range of motion, decrease the side effects of medication induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Acupuncture is allowed as a trial over 3-6 treatments and 1-3 times per week up to 1-2 months in duration with documentation of functional and pain improvement. Extension is also allowed beyond these limits if functional improvement is documented. In the case of this worker, there was a request for acupuncture, however, there was insufficient evidence to suggest other conservative modalities had been tried and failed before considering acupuncture. Also, there was no report which suggested physical therapy or home exercises were being recommended for the same time period, where acupuncture might be an adjunct. Therefore, the request for acupuncture will be considered medically unnecessary at this time.

**MRI left shoulder:** Upheld

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

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

**Decision rationale:** The MTUS Guidelines state that special testing such as MRIs for most patients with shoulder problems are not needed unless a four to six-week period of conservative care and observation fails to improve symptoms and are not recommended earlier than this unless red flags are noted on history or examination that raise suspicion of a serious shoulder condition. Muscle strains do not warrant special testing. Even cases of impingement or muscle tears of the shoulder area should be treated conservatively first, and only when considering surgery would testing such as MRI be helpful or warranted. After the initial course of conservative treatment over the 4-6 week period after the injury, MRI may be considered to help clarify the diagnosis in order to change the plan for reconditioning. The criteria for MRI of the shoulder include 1. Emergence of a red flag (intra-abdominal or cardiac problems presenting as shoulder problems), 2. physiologic evidence of tissue insult or neurovascular dysfunction such as cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis, or Raynaud's phenomenon, 3. failure to progress in a strengthening program intended to avoid surgery, and 4. Clarification of the anatomy prior to an invasive procedure such as in the case of a full thickness tear not responding to conservative treatment. In this case, the worker exhibited tenderness of the left shoulder, however, there was insufficient evidence of findings from physical examination which suggested a rotator cuff tear significant enough to warrant MRI imaging without more conservative care implemented first such as physical therapy and short-term medications, for example. At this time it does not seem appropriate or likely to be helpful to get an MRI of the left shoulder. The request is not medically necessary.

**MRI lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back section, MRI.

**Decision rationale:** MTUS Guidelines for diagnostic considerations related to lower back pain or injury require that for MRI to be warranted there needs to be unequivocal objective clinical findings that identify specific nerve compromise on the neurological examination (such as sciatica) in situations where red flag diagnoses (cauda equina, infection, fracture, tumor, dissecting/ruptured aneurysm, etc.) are being considered, and only in those patients who would consider surgery as an option. In some situations where the patient has had prior surgery on the back, MRI may also be considered. The MTUS also states that if the straight-leg-raising test on examination is positive (if done correctly) it can be helpful at identifying irritation of lumbar

nerve roots, but is subjective and can be confusing when the patient is having generalized pain that is increased by raising the leg. The Official Disability Guidelines (ODG) state that for uncomplicated low back pain with radiculopathy MRI is not recommended until after at least one month of conservative therapy and sooner if severe or progressive neurologic deficit is present. The ODG also states that repeat MRI should not be routinely recommended, and should only be reserved for significant changes in symptoms and/or findings suggestive of significant pathology. The worker in this case, the worker reported only brief 2-3 minute episodes of left leg pain which occurs on a daily basis. There was a positive straight leg raise and other testing which suggested muscle strain. However, these findings and subjective reports alone do not qualify this worker for an MRI of the lumbar spine. Also, there isn't enough evidence of the worker having fully tried other conservative care such as medications and physical therapy, for example. Therefore, the lumbar MRI will be considered medically unnecessary at this time.

**MRI cervical spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The MTUS ACOEM Guidelines state that for most patients presenting with true neck or upper back problems, special studies are not needed unless a 3-4 week period of conservative care and observation fails to improve symptoms. The criteria for considering MRI of the cervical spine includes: emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, looking for a tumor, and clarification of the anatomy prior to an invasive procedure. In the case of this worker, there was no subjective or objective physical findings or nerve testing which suggested a nerve impingement at the cervical spinal area to warrant MRI of the cervical spine. Although there were reports of neck and back and shoulder pain, without more significant findings, there isn't sufficient evidence to support such a request, and MRI is not likely to add to the worker's improvement. Conservative care should be fully implemented as well before considering additional tests. The cervical MRI will be considered medically unnecessary at this time.

**Sleep study:** 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) Mental Illness & Stress Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Polysomnography.

**Decision rationale:** The MTUS is silent on polysomnography (sleep study). The ODG, however, states that sleep studies may be conditionally recommended. Sleep studies are not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. The ODG lists criteria for polysomnography: 1. Excessive daytime sleepiness, 2. Cataplexy brought on by excitement or emotion, 3. Morning headache (with other causes ruled out), 4. Intellectual deterioration, 5. Personality change (not secondary to medication, cerebral mass, or known psychiatric problems), 6. Sleep-related breathing disorder or periodic limb movement disorder is suspected, and 7. Insomnia for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms is not recommended. In the case of this worker, and upon review of the documents provided, there was an explanation by the provider for this request, stating that the sleep study was requested because the worker reported difficulty sleeping due to pain. This is not a justifiable reason to have a sleep study. The purpose of a sleep study is to help discover if one has sleep apnea, and in this case the cause is already known (pain), therefore, this request is not medically necessary or appropriate.