

Case Number:	CM13-0026488		
Date Assigned:	11/22/2013	Date of Injury:	12/03/2011
Decision Date:	02/11/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	09/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois, Indiana and Texas. 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 physician 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:

The patient is a 66-year-old male who reported a work related injury on 12/03/2011, as a result of a fall. The patient currently presents for treatment of the following diagnoses: full thickness rotator cuff tear of the right shoulder, lumbar discogenic disease with radicular pattern to the bilateral lower extremities, and hypertension. The patient was seen in clinic on 08/16/2013 with complaints of continued right shoulder pain and lumbar spine pain. The examining provider, [REDACTED], documents the patient has utilized medication, activity modification, physical therapy, acupuncture, and chiropractic treatment for his pain complaints. Upon physical exam of the patient's right shoulder, the provider documented pain and tenderness over the posterior aspect of the shoulder with range of motion restricted. Range of motion about the right shoulder was noted to be at 110 degrees abduction, 50 degrees adduction, 80 degrees internal rotation, 70 degrees external rotation, 50 degrees extension and 120 degrees flexion. The provider documented there was tenderness noted over the posterior aspect of the lumbar paravertebral areas with the pain radiating to the bilateral feet. Range of motion of the lumbar spine revealed 45 degrees flexion, 15 degrees extension, 20 degrees bilateral/lateral bend and 20 degrees bilateral rotation. The provider reviewed an MRI of the lumbar spine dated 06/08/2012, which revealed lumbar spondylosis, mostly at the L4-5 level, where there is grade 1 anterolisthesis with a symmetric bulging disc resulting in severe spinal stenosis, bilateral recess stenosis, and severe bilateral neural foraminal narrowing. Additionally, there was spinal stenosis and bilateral neural foraminal narrowing at L5-S1, spinal stenosis, and bilateral neural foraminal narrowing at L2-3 and L3-4. The provider documented the patient is having over 40 sessions of physical therapy to the lumbar spine, conservative care, modified ADLs and modified work duty status,

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the spine: 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).

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

Decision rationale: The current request is not supported. Clinical documentation submitted for review fails to evidence that the patient presents with any significant objective findings and symptomatology upon physical exam to support repeat imaging study of the lumbar spine. The provider did not indicate the patient presented with any motor, neurological, or sensory deficits. The patient underwent an MRI of the lumbar spine in mid 2012. California MTUS/ACOEM indicates when the neurological examination is less clear further physiologic evidence and nerve dysfunction can be obtained before ordering an imaging study. Given the lack of any significant red flag findings upon exam of the patient, or progressive neurological deficits, the request for MRI of the lumbar spine is not medically necessary or appropriate.

Physical therapy four (4) times a week: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

Decision rationale: The California MTUS indicates to allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home physical medicine. The clinical notes document that patient previously was recommended to utilize a short course of therapy for the right shoulder symptomatology. However, documentation of the patient's duration and frequency, reports of efficacy with supervised therapeutic interventions, were not evidenced in clinical notes reviewed. At this point in the patient's treatment an independent home exercise program for continued motor strength and increased range of motion would be indicated. As such, the request for physical therapy 4 times a week is neither medically necessary nor appropriate.