

Case Number:	CM13-0046756		
Date Assigned:	12/27/2013	Date of Injury:	12/29/2012
Decision Date:	07/29/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/01/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/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 underlying date of injury in this case is 12/29/2012. This patient's diagnoses are cervical sprain, bilateral shoulder pain, left index finger pain, thoracic sprain, lumbar radiculopathy, psychological overlay with possible anxiety and depression, and hypertension due to anxiety. A primary treating physician initial evaluation report of 09/12/2013 reviews this patient's history of initial injury when an individual assaulted him. He noted the patient's complaints of ongoing neck pain, right shoulder pain, left shoulder pain, left index finger pain, and middle and low back pain. The patient was noted to have tenderness in the affected areas with reduced range of motion. The treating physician prescribed medication including Cyclobenzaprine, Naproxen, and Omeprazole and planned to obtain x-rays of the affected areas and begin physical therapy. The treating physician also planned a functional capacity evaluation to determine if the patient could seek gainful employment. The treating physician additionally planned to obtain all prior medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS TO THE LOW BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Non-MTUS ACOEM Practice Guidelines, Chapter 6: Pain, Suffering, Restoration of Function.

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

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on physical medicine, recommends that a patient should transition to an independent self-directed rehabilitation program. The medical records in this case do not review the patient's past physical therapy and do not provide a rationale as to why the patient at this time would require additional supervised therapy rather than continued independent home rehabilitation. This request is not supported by the guidelines. This request is not medically necessary.

LUMBAR MRI: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: The ACOEM Guidelines, chapter 12, low back, page 309, recommend lumbar MRI imaging when specific red flag factors or neurological findings have been identified. The records do not discuss such red flag findings at this time and do not clarify why imaging would be needed at this time versus first initial review of the patient's prior imaging studies. At this time the medical records and guidelines do not support this request. The requested lumbar MRI is not medically necessary.

EMG/NCS OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator 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.

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

Decision rationale: The ACOEM Guidelines, chapter 12, low back, page 303, recommend electrodiagnostic studies to evaluate for subtle, focal neurological dysfunction in patients with ongoing low back symptoms. In context, this guideline would anticipate an electrodiagnostic study to be performed after review of medical records and determination of a specific differential diagnosis. The medical records do not indicate that the treating physician first reviewed these records before recommending an electrodiagnostic study. This request for an electrodiagnostic study is not medically necessary.