

Case Number:	CM14-0024273		
Date Assigned:	06/11/2014	Date of Injury:	05/18/2009
Decision Date:	08/01/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	02/26/2014

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 injured worker is a 37-year-old with a reported date of injury on May 18, 2009. The injury reported occurred when the injured worker was working for 2 hours straight without a break in a stooped over position. Her diagnoses were noted to include cervical spine musculoligamentous sprain/strain with slight spondylosis, lumbar spine musculoligamentous sprain/strain with right lower extremity radiculitis with disc degeneration and disc protrusions at the L4-5 and L5-S1 levels with moderate foraminal stenosis at L4-5, and severe encroachment on the left lateral foramen with impingement on the exiting left nerve root per MRI, and 1 cm anterolisthesis of L5 on S1 with facet degeneration, bilateral shoulder parascapular strain, stress, anxiety, and sleep difficulty. Her previous treatments were noted to include a cortisone injection, medications, and physical therapy. The progress note dated May 9, 2014 revealed the injured worker complained of back pain radiating mainly to the right leg with associated numbness and tingling. The progress note dated January 14, 2014 revealed the injured worker complained of low back pain with occasional radiating pain to the right leg, neck pain radiating to the bilateral arms, right side greater than left, bilateral shoulder pain, right hip pain, stress, anxiety, and sleep difficulty. The physical examination of the cervical spine revealed a normal head carriage, slight to mild tenderness to palpation with muscle guarding was present over the paraspinal musculature. Mild tenderness to palpation with mild spasm was present over the trapezius muscles. The range of motion of the cervical spine was measured as flexion was to 46 degrees, extension was to 50 degrees, right rotation was to 70 degrees, left rotation was to 72 degrees, right side bending was to 40 degrees, and left side bending was to 40 degrees. The examination of the lumbar spine revealed mild tenderness to palpation with spasm was present over the paraspinal musculature, and midline tenderness to palpation was present over the lumbosacral junction. There was tenderness to palpation noted over the sacroiliac joints bilaterally, right side greater than left.

The straight leg raise test revealed increased back pain bilaterally, absent radicular component. The range of motion of the lumbar spine was noted as flexion was to 46 degrees, extension was to 20 degrees, right side bending was 21 degrees, and left side bending was 20 degrees. The examination of the bilateral shoulders revealed normal symmetry and contour. There was tenderness to palpation noted over the posterior scapular muscles and spasm was present over the trapezius muscles. There was subacromial crepitus noted on the left shoulder but absent on the right. The impingement and cross arm test elicited posterior shoulder girdle pain only. The range of motion to the shoulders was noted as flexion was to 170 degrees, extension was to 46 degrees, abduction was to 168 degrees, adduction was to 48 degrees, internal rotation was to 83 degrees, and external rotation was to 50 degrees to the right shoulder. The range of motion to the left shoulder was noted to be flexion was to 168 degrees, extension was to 42 degrees, abduction was to 160 degrees, adduction was to 40 degrees, internal rotation was to 80 degrees and external rotation was to 80 degrees. There was sensation to pinprick and light touch noted in the right lower extremity was decreased in a patch distribution. The motor testing of the major muscle groups of the bilateral upper and lower extremities revealed no weakness, and deep tendon reflexes were 2+ in the biceps, triceps, brachioradialis, patella and Achilles bilaterally. The provider reported an MRI dated February 21, 2010 revealed lumbar spine musculoligamentous sprain/strain with right lower extremity radiculitis with disc degeneration and disc protrusions at the L4-5 and L5-S1 levels with moderate foraminal stenosis at L4-5 and severe encroachment on the left lateral foramen with impingement on the exiting left nerve root, and 1 cm anterolisthesis of L5 on S1 with facet degeneration. An MRI dated February 12, 2014 revealed scoliotic curvature of the lumbar spine. At L5-S1, there was a 3 mm circumferential disc protrusion resulting in abutment of the exiting right and left L5 nerve roots. At L4-5, there is a 3 mm midline disc protrusion resulting in a mild effacement of the anterior thecal sac with no neural abutment or central canal narrowing. The request for authorization form dated January 14, 2014 was for physical therapy at a frequency of 3 times per week for 4 weeks, updated MRI scan of the lumbar spine, and a diagnostic ultrasound study of the left shoulder. However, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the low back and bilateral shoulders, three times per week for four weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, pages 98-99 Page(s): 98-99.

Decision rationale: The injured worker completed approximately 8 sessions of physical therapy noting only slight overall improvement. The California Chronic Pain Medical Treatment Guidelines recommend active therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion and

can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual, and/or tactile instructions. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include with or without mechanical assistance or resistance in functional activities with assistive devices. The guidelines recommend for myalgia and myositis 9 to 10 visits over 8 weeks. There is a lack of documentation regarding current objective functional deficits with regards to range of motion and motor strength, as well as quantifiable objective functional improvements from previous physical therapy. There is a lack of documentation from previous physical therapy visits and the request for twelve physical therapy sessions exceeds guideline recommendations. Therefore, the request for physical therapy for the low back and bilateral shoulders, three times per week for four weeks, is not medically necessary or appropriate.

MAGNETIC RESONANCE IMAGING (MRI) OF LUMBAR SPINE: 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): 303-305.

Decision rationale: The request for an MRI of the lumbar spine is non-certified. The injured worker has had a previous MRI on February 21, 2010. The Low Back Complaints Chapter of the ACOEM Practice Guidelines state unequivocal objective findings that identify a specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false positive findings such as disc bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging study to define a potential cause, such as an MRI for neural deficits. The guidelines state an MRI is used to identify and define low back pathology with regards to disc protrusion, cauda equina syndrome, spinal stenosis, and post laminectomy syndrome. The injured worker has received a previous two MRIs and an additional MRI is not warranted at this time. The documentation provided reported patchy numbness but no specific dermatomal pattern to the sensory loss, or weakness or reflex changes. Therefore, a repeat MRI is not medically necessary due to a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution or red flags to warrant a repeat MRI. Therefore, the request for an MRI of the lumbar spine is not medically necessary or appropriate.

DIAGNOSTIC ULTRASOUND OF LEFT SHOULDER: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Ultrasound, diagnostic.

Decision rationale: The request for a diagnostic ultrasound of the left shoulder is non-certified. The injured worker complained of pain to the left shoulder and the impingement elicited posterior shoulder girdle pain only. However, muscle strength and deep tendon reflexes were normal. The Official Disability Guidelines state the results of a recent review suggests that clinical examination by a specialist can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full thickness rotator cuff tears, although ultrasound may be better at picking up partial tears. Ultrasound also may be more cost effective in a specialist hospital setting for identification of full thickness tears. Ultrasound is a highly accurate imaging study for evaluating the integrity of the rotator cuff in shoulders that have undergone an operation. Its accuracy for operative treating shoulders appears to be comparable with that previously reported for shoulders that have not been operated on. The rotator cuff and its environment can be imaged in many ways. Preoperative ultrasound examination of the shoulder permits a reliable diagnosis of complete rotator cuff tears and calcium deposits. This method is less sensitive but sufficiently reliable for the diagnosis of partial rotator cuff tears and pathology of the long biceps tendon. The choice of which imaging test to perform should be based on the patient's clinical information, cause, and imaging experience of the radiology department. Ultrasound scan of the shoulder is an accurate and reliable method of detecting full thickness rotator cuff tears and it can reduce time from referral to definitive diagnosis and management. The physical examination revealed posterior shoulder girdle pain only with impingement and cross arm test. Additionally, the motor testing of the major muscle groups of the bilateral upper extremities revealed no weaknesses and the deep tendon reflexes were full and equal bilaterally. There is a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution. Therefore, the request for a diagnostic ultrasound of the left shoulder is not medically necessary or appropriate.