

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0037715 | | |
| Date Assigned: | 06/25/2014 | Date of Injury: | 12/02/2013 |
| Decision Date: | 07/28/2014 | UR Denial Date: | 03/24/2014 |
| Priority: | Standard | Application Received: | 03/28/2014 |

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 Pain Medicine and is licensed to practice in 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 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 65 year old female who sustained injuries to her left shoulder, knee, low back, and cervical spine on 12/03/13 due to being assaulted by an autistic student and having to restrain the child. The injured worker reported that the child was kicking at the side of her left knee. The injured worker rated her pain at 6/10 on the visual analog scale. The injured worker subsequently completed a 6 visit regimen of physical therapy that provided good results earlier in 2014. A clinical note dated 03/12/14 reported that the injured worker continues to complain of left knee pain that is bothersome and painful with prolonged weight bearing, squatting, and work duties. She reported increased complaints of cervical spine pain/headaches, especially with work and driving. It was reported that an MRI is pending (the injured worker unsure for which body parts). Physical examination noted bilateral lower extremity range of motion within functional limits with pain at full extension and tightness in the bilateral hip rotators; motor strength 5-/5 bilaterally; tenderness to palpation of the left MCL, distal ITB, medial joint line; tightness left greater than right in the upper thoracic, spine, levator scapulae, scalenes; good patellar mobility; hypo upper cervical mobility. The injured worker was diagnosed with bilateral shoulder strains, left knee ligament sprain, lumbar muscle sprain, and neck muscle sprain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging of the lumbar 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 lower back lumbar & Thoracic (acute & Chronic) MRI.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, MRIs (magnetic resonance imaging).

Decision rationale: The request for magnetic resonance imaging of the lumbar spine is not medically necessary. The previous request was denied on the basis that no prior treatment history, diagnostic imaging, or office documentation had been provided. It was reported that the injured worker was anticipating pending results from a previous MRI; however, the injured worker was unsure of the body part. There was no report of a new acute injury or exacerbation of previous symptoms. There was no mention that a surgical intervention had been performed or is anticipated. There were no physical examination findings of decreased motor strength, increased reflex or sensory deficits. There were no focal neurological deficits. There was no indication that plain radiographs were obtained prior to the request for more advanced MRI. There were no additional significant 'red flags' identified. Given this, the request for magnetic resonance imaging of the lumbar spine is not indicated as medically necessary.

Physical therapy three time a week for four weeks to the cervical;/lumbar spine and left shoulder.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Integrated Treatment/Disability Duration Guidelines for the upper neck and upper back (acute & chronic).

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The request for physical therapy 3 times a week times 4 weeks for the cervical/lumbar spine and left shoulder is not medically necessary. The records indicate that the injured worker is status post left shoulder arthroscopic surgery dated 01/24/14 with noted retracted and irreparable rotator cuff tear. A previous request for 6 visits was certified for additional physical therapy to address remaining functional deficits. After reviewing the clinical documentation provided for review, there was no additional significant objective information provided that would support the need to reverse the previous adverse determination. Given this, the request for physical therapy 3 times a week times 4 weeks for the cervical/lumbar spine and shoulder is not indicated as medically necessary.