

Case Number:	CM15-0135632		
Date Assigned:	08/21/2015	Date of Injury:	10/22/2002
Decision Date:	09/29/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	07/14/2015

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 York
 Certification(s)/Specialty: Internal Medicine

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 60-year-old male who sustained an industrial injury on 10-22-2002. Initial injuries are due to cumulative trauma. Previous treatments included medications, surgical intervention, physiotherapy, acupuncture, neck injections, and psychiatry. Previous diagnostic studies included a MRI's, x-rays. Current diagnoses include cervical disc disorder, cervical spondylosis without myelopathy, brachial neuritis or radiculitis, cervical strain-sprain, depressive disorder, anxiety-depression, and gastroesophageal reflux disease. Report dated 05-29-2015 noted that the injured worker presented with complaints that included left clavicular, right TMJ, left TMJ, headache, right clavicular, left anterior shoulder, right anterior shoulder, abdominal, left abdominal, right abdominal, left chest, sternal, left lumbar, lumbar, right sacroiliac, left sacroiliac, mid thoracic, left mid thoracic, right cervical dorsal, upper thoracic, right cervical, left cervical, cervical, headache, left posterior leg, left pelvic, right posterior wrist, right pelvic, sacral, right posterior leg, right posterior knee, left posterior knee, left calf, right ankle, left ankle, left foot, left posterior hand, right posterior hand, left posterior wrist, left posterior shoulder, left cervical dorsal, right posterior shoulder, right mid thoracic, right anterior leg, left anterior leg, right anterior knee, right ankle, right shin, left foot, left ankle, left anterior knee, right anterior hand, left anterior hand, left anterior wrist and right anterior wrist pain. Pain level was 9 (current), 10 (worst), and 7 (best) out of 10 on a visual analog scale (VAS). Also noted was numbness and tingling in the right TMJ, left TMJ, left cervical, cervical, and right cervical. Further complaints included anxiety, stress, and insomnia. Physical examination was positive for tenderness at the cervical, left and right dorsal cervical, upper thoracic, lumbar, left and right

sacroiliac, left and right buttock, sacral, left and right posterior leg, and left and right posterior knee, and decreased range of motion in the cervical and lumbar spine. The treatment plan included re-evaluation, request for medical records, physical therapy for the cervical and lumbar spine, request for MRI of the cervical spine and CT scan of the lumbar spine, request for shockwave therapy, prescribed compound topical medication, and hydrocodone. The injured worker remains totally temporarily disabled for 45 days and is to follow up in 45 days. Disputed treatments include one MRI of the cervical spine, one CT scan of the lumbar spine, one prescription of hydrocodone 10-325mg #60, and six physical therapy visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

One MRI of the cervical 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 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: According to the ACOEM neck and upper back complaints chapter, there is specific criteria. Criteria 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, clarification of the anatomy prior to an invasive procedure, and unequivocal findings that identify specific nerve compromise on the neurologic examination." The submitted documentation does not meet the criteria set by the ACOEM guidelines. Currently the injured worker is not enrolled in any therapy programs, and there is no mention of any plans for an invasive procedure. Therefore, the request for an MRI of the cervical spine is not medically necessary.

One CT scan 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 (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304, 309.

Decision rationale: According to ACOEM guidelines, Low Back Chapter 12 a "CT is an option for pre-op planning." The injured worker has had prior surgical intervention in the lower back. Review of submitted medical records does not provide clear rationale to support the appropriateness of this test in this injured worker. There are no red flags documented, nor is there any mention of surgery. Therefore, the request for one CT scan of the lumbar spine is not medically necessary.

One prescription of Hydrocodone 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement, Opioids section Page(s): 1, 74-96.

Decision rationale: The California MTUS chronic pain medical treatment guidelines recommend specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. "Recommendations include the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It is also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the use of the medication." The CA MTUS Guidelines define functional improvement as "a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management and a reduction in the dependency on continued medical treatment." Therapies should be focused on functional restoration rather than the elimination of pain. The medical records submitted for review does not include the above recommended documentation. There were no functional improvements noted with the use of the medications. The injured worker's work status remains unchanged and there is no change on medical dependence. Therefore, the request for one prescription of Hydrocodone 10/325mg #60 is not medically necessary.

Six physical therapy visits: 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): 98-99.

Decision rationale: The California Chronic Medical Treatment Guidelines note that active therapy is 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. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. Documentation supports that the injured worker has received prior physical therapy. There were no progress notes from any of the prior therapy, nor was the number of previously completed physical therapy included. The records are not clear about the objective outcome of prior physical therapy, Also there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. Therefore, the request for physical therapy 6 visits is not medically necessary.