

Case Number:	CM15-0146609		
Date Assigned:	08/07/2015	Date of Injury:	03/01/2015
Decision Date:	09/18/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/28/2015

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: California

Certification(s)/Specialty: Emergency 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 59 year old male, who sustained an industrial injury on 3-1-15. Documentation provided is poor with only a single progress note submitted for review. The injured worker has complaints of pain in the neck, mid and upper back, lower back, right shoulder, right hip and right knee pain. The documentation noted that there is 2 to 3 tenderness to palpation over the paraspinal muscles, which has increased from grade 2. The documentation noted there is restricted range of motion and cervical compression test is positive. Lumbar spine has grade three tenderness to palpation over the paraspinal muscles; right shoulder has tenderness to palpation. Right hip there is grade 2 to 3 tenderness to palpation, which has increased from grade tow and right knee and lower leg has 2 to 3 tenderness t palpation. The diagnoses have included sprain of lumbar and thoracic or lumbosacral neuritis or radiculitis, unspecified. Treatment to date has included physical therapy; tramadol; theramine; fexmid and topical cream. The request was for continue physical therapy 3 times a week for 4 weeks for the cervical spine; continue physical therapy 3 times a week for 4 weeks for the lumbar spine; continue physical therapy 3 times a week for 4 weeks for the right upper extremity; magnetic resonance imaging (MRI) of the lumbar spine and extracorporeal shockwave therapy once a week for 4 weeks for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue physical therapy 3 times a week for 4 weeks for the cervical spine: Upheld

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

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

Decision rationale: As per MTUS Chronic pain guidelines physical therapy is recommended for many situations with evidence showing improvement in function and pain. Guidelines also recommend only up to 10 PT sessions for the diagnosis listed and only additional sessions if there is documentation of objective improvement in pain and function. Patient has already completed 6 prior sessions with no documentation of improvement. The additional 12 sessions requested will exceed recommended sessions and with no documentation of efficacy does not meet guideline criteria. Additional cervical spine Physical Therapy is not medically necessary.

Continue physical therapy 3 times a week for 4 weeks for the lumbar spine: Upheld

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

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

Decision rationale: As per MTUS Chronic pain guidelines physical therapy is recommended for many situations with evidence showing improvement in function and pain. Guidelines also recommend only up to 10 PT sessions for the diagnosis listed and only additional sessions if there is documentation of objective improvement in pain and function. Patient has already completed 6 prior sessions with no documentation of improvement. The additional 12 sessions requested will exceed recommended sessions and with no documentation of efficacy does not meet guideline criteria. Additional lumbar spine Physical Therapy is not medically necessary.

Continue physical therapy 3 times a week for 4 weeks for the right upper extremity: Upheld

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

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

Decision rationale: As per MTUS Chronic pain guidelines physical therapy is recommended for many situations with evidence showing improvement in function and pain. Guidelines also recommend only up to 10 PT sessions for the diagnosis listed and only additional sessions if there is documentation of objective improvement in pain and function. Patient has already completed 6 prior sessions with no documentation of improvement. The additional 12 sessions

requested will exceed recommended sessions and with no documentation of efficacy does not meet guideline criteria. Additional right upper extremity Physical Therapy is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, MRIs.

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

Decision rationale: As per ACOEM Guidelines, imaging studies should be ordered in event of “red flag” signs of symptoms, signs of new neurologic dysfunction, clarification of anatomy prior to invasive procedure or failure to progress in therapy program. Patient does not meet any of these criteria. There is no documented red flag findings in complaints or exam. Physical therapy is still ongoing and no other conservative measures have been attempted or completed. There is no noted new neurologic dysfunction. Patient has no basic imaging, There is no justification documented for why MRI lumbar spine was needed. MRI of lumbar spine is not medically necessary.

Extracorporeal shockwave therapy once a week for 4 weeks for the right 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 (ODG), Extracorporeal shockwave therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Extracorporeal shock wave therapy (ESWT).

Decision rationale: MTUS Chronic pain and ACOEM Guidelines do not have any sections that relate to this topic. As per Official Disability Guidelines, Extracorporeal Shockwave therapy is Recommended for calcifying tendinitis but not for other shoulder disorders. Patient does not have calcific tendinosis. ESWT is not medically necessary.