

Case Number:	CM15-0223917		
Date Assigned:	11/20/2015	Date of Injury:	07/14/2015
Decision Date:	12/30/2015	UR Denial Date:	11/05/2015
Priority:	Standard	Application Received:	11/13/2015

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, Indiana, 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 61-year-old male who sustained an industrial injury on 07-14-2015. Medical records indicated the worker was treated for left shoulder derangement, lumbar myalgia, lumbar myospasm, and lumbar neuritis-radiculitis. In the provider notes of 09-28-2015, the worker complains of intermittent bilateral shoulder pain left greater than right. His pain on a scale of 0-10 is rated a 5 while at rest and a 9 with activities. The shoulder pain is associated with weakness and numbness. It radiates to the neck. He also has constant low back pain that is cramping in character. The low back pain is associated with numbness and radiates to the bilateral hip, leg and feet. On a scale of 0-10, the pain is rated a 7 while at rest and a 10 with activities. He reports the pain is worse with bending to the left and right, twisting to left and right, sitting, lifting and walking. He has frequent right leg pain that is cramping in character. On a scale of 0-10, he rates his pain as a 3 while at rest and a 5 with activities. The pain radiates to his right foot and is associated with weakness, numbness and tingling. He reports his pain is worse in the evening, and with bending to the left and right, twisting to the left and right, lifting and walking. The pain interferes with activities of daily living. On examination, there is tenderness over the biceps groove, supraspinatus complex, rotator cuff and acromioclavicular joint. Neer and Hawking-Kennedy tests were positive. Manual muscle testing revealed 4-5 strength with range of motion. The lumbar spine has tenderness over the paravertebral region, spinous process and sacroiliac joints regions bilaterally. Trigger points were noticeable in the paraspinal muscles bilaterally. The worker was able to perform heel and toe walk with pain bilaterally. Seated straight leg raise test was positive bilaterally. Manual muscle testing revealed

3 out of 5 strength with flexion, extension and bilateral lateral bend. Range of motion was restricted due to pain and spasm and weakness in the right foot was noted. Motor examination revealed decreased motor strength to L5-S1. The treatment plan was to obtain a MRI of the lumbar spine, Electromyogram nerve conduction velocity studies of the lower extremities, and arrange for physical therapy evaluation and treat for lumbar spine and left shoulder three times a week. A request for authorization was submitted for: 1. MRI of the Lumbar Spine; 2. EMG/ NCV studies of the lower extremities; 3. Physical therapy 3x4 weeks for the low back; 4. Physical Therapy 3x4 weeks for the Left Shoulder. A utilization review decision 11-05-2015 denied: MRI of the Lumbar Spine authorized; EMG/NCV studies of the lower extremities modified to authorize; Physical therapy for the low back 2 times a week for 3 weeks only; Physical therapy for the left shoulder 2 times a week for 3 weeks only

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, MRI lumbar spine.

Decision rationale: Pursuant to the Official Disability Guidelines, MRI of the lumbar spine is not medically necessary. MRIs of the test of choice in patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, it is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. Indications (enumerated in the official disability guidelines) for imaging include, but are not limited to, lumbar spine trauma, neurologic deficit; uncomplicated low back pain with red flag; uncomplicated low back pain prior lumbar surgery; etc. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. See the ODG for details. In this case, the injured worker's working diagnoses are left shoulder derangement; lumbar myalgia; lumbar myospasm; and lumbar neuritis/radiculitis. Date of injury is July 14, 2015. Request for authorization is October 29, 2015. The medical record contains 22 pages. According to the initial orthopedic evaluation dated September 20, 2015, the injured worker received a six-visit course of physical therapy July 22, 2015. Physical therapy was "of no help". The region for physical therapy was not specified, although the anatomical region's subjectively complained to include low back pain and left shoulder. An MRI of the left shoulder was performed, but the results were not present to record. Subjective complaints include bilateral shoulder pain. There was low back pain 7/10 that radiated to the hips and legs. There was right leg pain with weakness, numbness and tingling. Objectively, there was tenderness in the paraspinal muscles spasm in the bilateral lumbar paraspinal muscles. There were trigger points. There was positive

straight leg raising. Motor strength was 3/5. It was decreased range of motion. The treating provider requested an EMG/NCV, in addition to the MRI of the lumbar spine. The EMG/NCV should be performed prior to the MRI lumbar spine. Pending results of the EMG NCV, an MRI of the lumbar spine may be considered clinically indicated. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and pending EMG/NCV studies, MRI of the lumbar spine is not medically necessary.

Physical therapy 3x4 weeks for the low back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy three times per week times four weeks the low back is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are left shoulder derangement; lumbar myalgia; lumbar myospasm; and lumbar neuritis/radiculitis. Date of injury is July 14, 2015. Request for authorization is October 29, 2015. The medical record contains 22 pages. According to the initial orthopedic evaluation dated September 20, 2015, the injured worker received a six-visit course of physical therapy July 22, 2015. Physical therapy was "of no help". The region for physical therapy was not specified, although the anatomical region's subjectively complained to include low back pain and left shoulder. An MRI of the left shoulder was performed, but the results were not present to record. Subjective complaints include bilateral shoulder pain. There was low back pain 7/10 that radiated to the hips and legs. There was right leg pain with weakness, numbness and tingling. Objectively, there was tenderness in the paraspinal muscles spasm in the bilateral lumbar paraspinal muscles. There were trigger points. It was positive straight leg raising. Motor strength was 3/5. There was decreased range of motion. As noted above, the injured worker received a six visit clinical trial of physical therapy. The physical therapy was of no help. Pending objective functional improvement from physical therapy, additional physical therapy may be clinically indicated. There was no documentation demonstrating objective functional improvement, in addition to the area being treated. Additionally, the treating provider requested an excessive number of physical therapy sessions (#12). There were no compelling clinical facts indicating additional physical therapy in excess of the recommended guidelines is clinically indicated. Based on the clinical information in the medical record, the peer-reviewed evidence-based guidelines, no documentation demonstrating objective functional improvement and no documentation stating the area that was treated, physical therapy three times per week times four weeks the low back is not medically necessary.

Physical Therapy 3x4 weeks for the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy three times per week times four weeks to the left shoulder again is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are left shoulder derangement; lumbar myalgia; lumbar myospasm; and lumbar neuritis/radiculitis. Date of injury is July 14, 2015. Request for authorization is October 29, 2015. The medical record contains 22 pages. According to the initial orthopedic evaluation dated September 20, 2015, the injured worker received a six-visit course of physical therapy July 22, 2015. Physical therapy was "of no help". The region for physical therapy was not specified, although the anatomical region is subjectively complained to include low back pain and left shoulder. An MRI of the left shoulder was performed, but the results were not present to record. Subjective complaints include bilateral shoulder pain. There was low back pain 7/10 that radiated to the hips and legs. There was right leg pain with weakness, numbness and tingling. Objectively, there was tenderness in the paraspinal muscles spasm in the bilateral lumbar paraspinal muscles. There were trigger points. It was positive straight leg raising. Motor strength was 3/5. There was decreased range of motion. As noted above, the injured worker received a six visit clinical trial of physical therapy. The physical therapy was of no help. Pending objective functional improvement from physical therapy, additional physical therapy may be clinically indicated. There was no documentation demonstrating objective functional improvement, in addition to the area being treated. Additionally, the treating provider requested an excessive number of physical therapy sessions (#12). There were no compelling clinical facts indicating additional physical therapy in excess of the recommended guidelines is clinically indicated. Based on the clinical information in the medical record, the peer-reviewed evidence-based guidelines, no documentation demonstrating objective functional improvement and no documentation stating the area that was treated, physical therapy three times per week times four weeks to the left shoulder is not medically necessary.