

Case Number:	CM15-0080382		
Date Assigned:	05/01/2015	Date of Injury:	03/10/2010
Decision Date:	06/29/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	04/27/2015

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: Family Practice

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 55-year-old female, who sustained an industrial injury on 3/10/2010, while breaking down boxes for pallets. The injured worker was diagnosed as having right shoulder full thickness rotator cuff tear, right shoulder impingement, and right cervicotrapipezius strain. Treatment to date has included diagnostics, physical therapy (2010 with worsening pain), and medications. Magnetic resonance imaging of the right and left shoulders (4/06/2015) were submitted. Recent progress reports were not submitted. In 11/2011, the injured worker complained of daily pain in her right shoulder, intensity dependent on activity level. She did home exercises and used non-steroidal anti-inflammatory drugs and occasional narcotics and muscle relaxants. A progress report with rationale for the requested open magnetic resonance imaging of the cervical and lumbar spines, physical therapy, and KeraTek gel was not noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Open MRI of cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute and Chronic) Chapter, MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Table 8-1 and Algorithm 8-3.

Decision rationale: The MTUS/ACOEM Guidelines comment on the evaluation of patients with neck and upper back complaints. Within these guidelines are recommendations for diagnostic studies to include imaging. Table 8-1 provides the recommendations for assessment; specifically, that the clinician should query the patient for any evidence of red flag symptoms which would suggest the potential for a serious underlying condition. Based on a review of the available records, there is no evidence that the patient has any of the red flag signs that suggest the need for further assessment of a serious underlying condition. Algorithm 8-3 provides recommendations for the evaluation of slow-to-recover patients with occupational neck and upper back complaints. The rationale for imaging studies is based primarily on evidence for red flag symptoms or the presence of physical examination findings consistent with neurologic impingement. Based on a review of the available records, there is no documentation provided to indicate that this patient has symptoms or signs of neurologic impingement involving the neck. Finally, the records indicate that the patient had prior imaging of the cervical spine with an MRI in October 2014. There is no evidence in the records to suggest that the patient's clinical symptoms or examination findings have changed substantially since that time. For these reasons, an MRI of the cervical spine is not considered as medically necessary.

Open MRI of 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-Lumbar and Thoracic (Acute and Chronic), MRIs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-1, Table 12-8, Algorithm 12-3.

Decision rationale: The MTUS/ACOEM Guidelines comment on the evaluation of patients with low back complaints. In the evaluation of a patient with a low back complaint, the clinician should assess and document evidence of any red flags which may indicate the presence of a serious underlying condition. These red flags are described in Table 12-1. In this case, there is no documentation in the medical records of any of these red flag conditions. The medical records should also document evidence of an appropriate history and physical examination in the ongoing assessment of a low back complaint. These are described in Table 12-8 of the MTUS/ACOEM guidelines. In this case, there is insufficient documentation that the treating physician has assessed the patient's ongoing symptoms of back pain and physical examination findings specific to the assessment of the low back. Finally, Algorithm 12-3 comments on the evaluation and management of slow-to-recover patients with an occupational low back complaint. Imaging studies are typically recommended when there is evidence of nerve root compromise. In this case, there is insufficient documentation to indicate that this patient has a nerve root compromise affecting the back. For these reasons, an MRI of the lumbar spine is not considered as medically necessary.

Physical therapy 2 times a week for 6 weeks for cervical spine/lumbar spine/bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute and Chronic), Low Back-Lumbar and Thoracic (Acute and Chronic) Chapters, Physical therapy.

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of physical therapy as a treatment modality. In general, physical therapy is a recommended as a treatment modality; however, there are specific recommendations as to the number of allowed sessions. The Physical Medicine Guidelines state the following: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home exercise program. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeks. In this case, the records indicate that the patient has received an unspecified number of physical therapy sessions. It is unclear whether the patient has already exceeded the recommended number of sessions; however, the request for 12 sessions clearly exceeds these above cited MTUS recommendations. Further, it is unclear whether there is any evidence that the patient benefited from the prior physical therapy sessions; specifically, objective evidence of improved pain control and functional abilities. For these reasons, 12 sessions of physical therapy is not considered as medically necessary.

Kera-Tek analgesic gel 4 oz bottle: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 105; 111-113.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of topical analgesics for the treatment of pain. This specific request is for Kera-Tek, which is a topical agent containing menthol and methyl salicylate. In general, the MTUS guidelines state that topical salicylates are recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. These agents are available over-the-counter. It is not stated in the records why the specific brand, Kera-Tek, is medically necessary, as again, this formulation is available without a prescription. Without justification for use of this specific brand of methyl salicylate, use of Kera-Tek analgesic gel is not considered as medically necessary.