

Case Number:	CM15-0086605		
Date Assigned:	05/11/2015	Date of Injury:	01/19/2015
Decision Date:	06/30/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/05/2015

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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50 year old male who sustained an industrial injury on January 19, 2015. He has reported lumbar spine and bilateral leg pain and has been diagnosed with chronic lumbar strain, rule out disc herniation and lower extremity radicular pain. Treatment has included physical therapy, medical imaging, and medications. Currently the injured worker has loss of range of motion to the lumbar spine. There was a positive straight leg raise on the right at 60 degrees with radiation of pain into the anterolateral thigh. Examination of the right shoulder revealed a loss of range of motion. There was positive impingement signs including Neer's and Hawkin's impingement signs. The treatment request included physical therapy, topical compound cream, MRI of the lumbar spine, and EMG of the bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy (2x6) to the lumbar spine and right shoulder: Upheld

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

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

Decision rationale: The patient presents with pain affecting the right shoulder and lower back. The current request is for Physical Therapy (2x6) to the lumbar spine and right shoulder. The treating physician states in the report dated 3/30/15, "In regards to the right shoulder, we are recommending that he continue physical therapy for continued functional improvement." (34B) The MTUS guidelines state, "They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process" and MTUS only allows 8-10 sessions of physical therapy. In the records provided for review for this case, the treating physician has not documented how many prior physical therapy sessions the patient has completed. There is no documentation of any recent surgery, flare-up, new injury or new diagnosis that would require additional physical therapy and there is no discussion as to why the patient is not currently able to transition to a home exercise program. The current request is not medically necessary and the recommendation is for denial.

Topical Compound: Flurbiprofen 20%, Lidocaine 5% 180gm: 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): 111-113.

Decision rationale: The patient presents with pain affecting the right shoulder and lower back. The current request is for Topical Compound: Flurbiprofen 20%, Lidocaine 5% 180gm. The treating physician states in the report dated 3/30/15, "I would like to request authorization for Flurbiprofen/Lidocaine cream for additional pain relief." (34B) The MTUS Guidelines page 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." Per MTUS guidelines, lidocaine is only allowed in a patch form and not allowed in a cream, lotion, or gel forms. Recommendation is for denial. The request is not medically necessary.

MRI of the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back MRIs.

Decision rationale: The patient presents with pain affecting the right shoulder and lower back. The current request is for MRI of the lumbar spine. The treating physician states in the report dated 3/30/15, "Based on my clinical examination, the patient is in need of MRIs as he has failed all conservative treatment measures performed up until he presented to this examiner." (34B) The ODG guidelines support MRI scans for patients with lower back pain with radiculopathy and other red flags. In this case, the treating physician has documented that the patient has radiating pain into the bilateral extremities and has weakness. The patient has not had an MRI scan done prior to this request and the pain is worsening. The current request is medically necessary and the recommendation is for authorization.

EMG of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Online, Cervical chapter: Electromyography (EMG)).

Decision rationale: The patient presents with pain affecting the right shoulder and lower back. The current request is for EMG of the bilateral upper extremities. The treating physician states in the report dated 3/30/15, "We have requested previously MRI of the lumbar spine as well as electrodiagnostic testing." (34B) The ODG guidelines state, "Recommended as an option in selected cases." If the physician has documented radiating pain into the extremity, and the physician requires differentiation of carpal tunnel syndrome vs. cervical radiculopathy or double crush syndrome, then an EMG of the upper extremity is medically necessary. If there is neck or arm symptoms or both lasting longer than 3-4 weeks then it is medically necessary. In this case, the treating physician has not documented any symptoms of radiculopathy in the upper extremities and the patient has not had neck or arm symptoms lasting longer than 3-4 weeks. The current request is not medically necessary and the recommendation is for denial.