

Case Number:	CM15-0240060		
Date Assigned:	12/17/2015	Date of Injury:	09/06/2014
Decision Date:	01/21/2016	UR Denial Date:	12/08/2015
Priority:	Standard	Application Received:	12/09/2015

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: North Carolina
 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:

This is a 30 year old female with a date of injury of September 6, 2014. A review of the medical records indicates that the injured worker is undergoing treatment for left shoulder pain, neck pain, myalgia, left rotator cuff syndrome, and chronic pain syndrome. Medical records dated September 8 2015 indicate that the injured worker complained of pain rated at a level of 6 out of 10. Records also indicate that the injured worker reported benefiting from medications, with a 50% reduction in pain. A progress note dated December 2, 2015 documented complaints of pain rated at a level of 6 out of 10 and less pain with stabilization of the back with bracing. Per the treating physician (December 2, 2015), the employee had restrictions that included no lifting over 30 pounds, no repetitive above the left shoulder, no repetitive grasping with the left hand, no prolonged sitting over 60 minutes, and prolonged standing or walking over 60 minutes, and allowance for stretching breaks every 15 minutes every hour. The physical exam dated September 8, 2015 reveals tenderness to palpation of the left trapezius, and decreased range of motion of the left shoulder. The progress note dated December 2, 2015 did not document a physical examination. Treatment has included lumbar spine bracing, medications (Pamelor, Lidopro cream, and Gabapentin). The treating physician documented that the injured worker had not had magnetic resonance imaging of the lumbar spine in the past. The utilization review (December 8, 2015) non-certified a request for six sessions of physical therapy for the left shoulder, cervical spine, and lumbar spine, and magnetic resonance imaging of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, six sessions for the left shoulder, cervical spine, and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. 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; Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The patient has already completed physical therapy. The request is in excess of these recommendations per the California MTUS. There is no objective reason why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions In the provided clinical documentation. Therefore the request is not medically necessary.

MRI for 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, MRIs.

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

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of

diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore the request is not medically necessary.