

Case Number:	CM14-0129497		
Date Assigned:	08/18/2014	Date of Injury:	12/21/2010
Decision Date:	10/24/2014	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	08/14/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 64-year-old male with a 12/21/10 date of injury. At the time (7/3/14) of request for authorization for MRI of the cervical and lumbar spine, and Physical Therapy 2x3 weeks (6 sessions) for the bilateral shoulder, cervical and lumbosacral, there is documentation of subjective (ongoing lower back and neck pain) and objective (tenderness to palpitation over the cervical and lumbar paraspinal muscles bilaterally, decreased range of motion of cervical and lumbar spine, and positive straight leg raise test) findings, imaging findings (reported MRI of the cervical spine (3/20/11) revealed minimal spondylosis throughout cervical spine, severe bilateral neuroforaminal narrowing and mild to moderate canal stenosis in C3-4; moderate to severe bilateral neuroforaminal narrowing and mild canal stenosis in C4-5, C5-6, and C6-7; moderate right neuroforaminal narrowing in C7-T1; congenital stenosis of the thecal sac; report not available for review. Reported MRI lumbar spine (3/20/11) revealed moderate right and moderate to severe left neuroforaminal narrowing and mild canal stenosis in L3-4; and moderate left and moderate to severe right neuroforaminal narrowing and mild canal stenosis in L4-5; report not available for review), current diagnoses (bilateral shoulder tendinitis, cervical sprain with radicular symptoms, and lumbosacral sprain), and treatment to date (Epidural injections, acupuncture, physical therapy, and medications). Medical reports identify that the patient has had maximum number of physical therapy treatments to the shoulder. The number of previous physical therapy treatments cannot be determined. Regarding MRI, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeated study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of

physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Regarding physical therapy, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 179-183, 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG,) Minnesota Rules, Parameters for Medical Imaging

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative, physiologic evidence (in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans) of tissue insult or neurologic dysfunction, failure of conservative treatment; or diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure; as criteria necessary to support the medical necessity of an MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder tendinitis, cervical sprain with radicular symptoms, and lumbosacral sprain. However, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeated study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for MRI of the cervical and lumbar spine is not medically necessary.

Physical Therapy 2x3 weeks (6 sessions) for the bilateral shoulder, cervical and lumbosacral: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Neck & Upper Back, and Low Back, Physical Therapy (PT)

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of sprained shoulder not to exceed 10 visits over 8 weeks, patients with a diagnosis of cervical radiculitis not to exceed 12 visits over 10 weeks, and patients with a diagnosis of lumbar strain not to exceed 10 visits over 8 weeks. ODG also notes 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 a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder tendinitis, cervical sprain with radicular symptoms, and lumbosacral sprain. In addition, there is documentation of previous physical therapy treatments and a rationale identifying that the patient has had maximum number of physical therapy treatments to the shoulder. However, there is no documentation of the number of previous physical therapy sessions and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Physical Therapy 2x3 weeks (6 sessions) for the bilateral shoulder, cervical and lumbosacral is not medically necessary.