

Case Number:	CM14-0161990		
Date Assigned:	10/07/2014	Date of Injury:	03/03/2014
Decision Date:	10/30/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/02/2014

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 Occupational Medicine 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:

There were 242 pages provided for this review. This is a request for an outpatient total lumbar weight-bearing MRI and follow-up with [REDACTED] and additional rehabilitation for 12 sessions. There was a request for independent medical review dated October 1, 2014. Per the records provided, the diagnoses included a sprain of the shoulder, sprain of the neck, osteoarthritis of the shoulder and chronic osteomyelitis of the hand. There was also a sprain of the rotator cuff. They recommended certification of the follow-up visit with [REDACTED], but non certification for the lumbar weight-bearing MRI in the additional rehabilitation. The claimant was described as a 50-year-old man injured at work on March 3, 2014. The injury was described as the claimant was shoveling dirt into a hole when he slipped and fell into the hole, landing on the right side resulting in injuries to his back, right knee and shoulder. He was initially authorized six physical therapy treatments and referred for an orthopedic evaluation. He was then authorized six visits of chiropractic care. On July 14, 2014, he had right shoulder subacromial decompression and 12 sessions of postoperative therapy. The patient had some improvement with postoperative rehabilitation. He was having increased lower back pain, neck pain, headaches and knee pain. The therapy would include passive spinal manipulation, passive e-stim and ultrasound. There was no evidence of neurologic deficits that would necessitate the MRI. Straight leg raise was positive bilaterally but there is no mention that there were other radiculopathy signs.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT TTDI (TOTAL) LUMBAR WEIGHT BEARING MRI: Upheld

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

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

Decision rationale: Under MTUS/ACOEM, although there is subjective information presented in regarding increasing pain, there are little accompanying physical signs. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note '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.' The guides warn that indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. I did not find electrodiagnostic studies. It can be said that ACOEM is intended for more acute injuries; therefore other evidence-based guides were also examined. The ODG guidelines note, in the Low Back Procedures section:- Lumbar spine trauma: trauma, neurological deficit- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)- Uncomplicated low back pain, suspicion of cancer, infection- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)- Uncomplicated low back pain, prior lumbar surgery- Uncomplicated low back pain, cauda equina syndrome It was not clear from the notes what weight bearing images would add strategically. Ultimately, these criteria are also not met in this case; the request was appropriately non-certified under the MTUS and other evidence-based criteria.

ADDITIONAL REHAB 12 SESSIONS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified: 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in

the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite:1. Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient...Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general.2. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization.This request for more skilled, monitored therapy, especially a regimen of largely passive modalities was appropriately non-certified.