

Case Number:	CM14-0163107		
Date Assigned:	10/08/2014	Date of Injury:	08/08/2013
Decision Date:	11/07/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/03/2014

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:

Injured worker is a male with date of injury 8/8/2013. Per initial orthopedic consultation, the injured worker complains of constant low back pain radiating into the right buttock area. Pain increases with bending, lifting, pulling, pushing, turning, and twisting. He also has constant pain in the right shoulder that increases with lifting, pulling, pushing, turning and sleeping on his shoulder. On examination of his right shoulder there is pain on flexion, extension, abduction, external rotation. Impingement sign is positive. Apprehension sign is positive. Range of motion of the right shoulder is reduced in flexion, abduction, external rotation and internal rotation is comparison to the left shoulder. Lumbar spine has paravertebral muscle spasm. There is tenderness at the lumbosacral junction, at L4, L5, S1 and S2 spinous processes. He walks with an antalgic gait, and difficulty with toe walking, heel walking, and kneeling and squatting. Lumbar spine range of motion is flexion 30 degrees, extension 20 degrees, right bending 20 degrees, and left bending 20 degrees. There is no sensory or motor deficit noted. Diagnoses include 1) chronic lumbosacral sprain and strain with possible sacral lesion maybe a giant cell tumor or an enchondroma 2) shoulder impingement syndrome, right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat MRI Lumbar Spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 297, 303, 304, 309.

Decision rationale: The MTUS Guidelines do not recommend the routine use of MRI with low back complaints. MRI should be reserved for cases where there is physiologic evidence that tissue insult or nerve impairment exists, and the MRI is used to determine the specific cause. MRI is recommended if there is concern for spinal stenosis, cauda equine, tumor, infection or fracture is strongly suspected, and x-rays are negative. This is noted to be a request for a repeat MRI of the lumbar spine. The requesting physician explains that the injured worker has a giant cell tumor on the MRI scan, and that it needs to be repeated to see if the tumor is staying still or it is expanding. The request for Repeat MRI Lumbar Spine is determined to be medically necessary.

Repeat MRI Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 217. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers' Comp 2012

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: Per the MTUS Guidelines, the criteria for ordering imaging studies of the shoulder include emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The injured worker has been diagnosed with impingement syndrome, but the clinical documents do not provide evidence of failing conservative therapy. This is also noted to be a request for a repeat MRI, and there is no explanation of a significant interval change that may indicate that a repeat MRI is necessary. Medical necessity has not been established for this request within the recommendations of the MTUS Guidelines. The request for Repeat MRI Right Shoulder is determined to not be medically necessary.

Med Consult: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7) page 127

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 78, 79, 90.

Decision rationale: Per the MTUS Guidelines, the clinician acts as the primary case manager. The clinician provides medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine usage and referral. The

clinician should judiciously refer to specialists who will support functional recovery as well as provide expert medical recommendations. Referrals may be appropriate if the provider is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. The requesting physician is an orthopedic surgeon, referring to an internist for blood pressure management. Causation of hypertension is beyond the scope of this review, however, a referral to an internist for management of hypertension is appropriate and medically necessary. The requesting physician states that the injured worker's hypertension is probably secondary to medication. The request for Med consult is determined to be medically necessary.

Physical Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

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

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified, receive 9-10 visits over 8 weeks. The injured worker has been injured over one year. The number of sessions of physical therapy completed to date is not explained, and the response to previous therapy is not reported. At this point in the injured worker's care it would be expected that he has a home exercise program for continued rehabilitation of his injuries, but this is not addressed in the current medical report. The request also does not explain what body part the therapy is for. The number of sessions (two times a week for six weeks) is in excess of the number of sessions recommended by the MTUS Guidelines. Medical necessity of this request has not been established with the recommendations of the MTUS Guidelines. The request for Physical therapy is determined to not be medically necessary.