

Case Number:	CM13-0036277		
Date Assigned:	12/13/2013	Date of Injury:	01/06/2010
Decision Date:	02/19/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 physician 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:

The patient is a 58-year-old male who reported an injury on January 06, 2010. The mechanism of injury was not provided for review. The patient developed cervical, thoracic, and low back pain. Previous treatments included physical therapy, medications, and epidural steroid injections. The patient's most recent clinical evaluation revealed persistent thoracic and low back pain. The patient's pain was described as 4/10 with medications and 6/10 without medications. Physical examination findings included decreased range of motion of the lumbar spine, a positive straight leg raising test bilaterally, tenderness to palpation along the T3 to the T4 and T4-5 facets bilaterally with sensory deficits in the T3-5 dermatomes. The patient's diagnoses included chronic pain syndrome, cervicgia, spondylosis of the cervical spine, cervical radiculopathy, lumbar back pain, paresthesia of the lower extremities, and myofascial pain syndrome. The patient's treatment plan included MRIs of the low back and thoracic spine in combination with lumbar x-rays and thoracic x-rays, continued participation in a home exercise program, aquatic therapy, and epidural steroid injections for the lumbar and thoracic spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

one (1) MRI of the thoracic 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 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient had a previous imaging study that did not reveal any significant abnormal findings. The Official Disability Guidelines do not recommend repeat imaging in the absence of significant progression of neurological deficits or a change in pathology. Although the documentation does indicate that the patient has had an increase in pain, there is no documentation that the patient has recently undergone any physical therapy to assist with pain control. As there is no documentation that the patient has received any recent conservative therapy for this newly developed pain and the patient has had a previous MRI, an additional MRI would not be supported. As such, the requested MRI of the thoracic spine is not medically necessary or appropriate.

one (1) MRI of the lumbar spine: 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): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI.

Decision rationale:

one (1) x-ray of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Radiography.

Decision rationale: The ACOEM guidelines do not support radiographic imaging in the absence of red flag symptoms for serious spinal pathology unless the physician believes it would aid in treatment planning. The clinical documentation submitted for review does provide evidence that the physician is ordering the radiographic studies to support the need for an epidural steroid injection. However, the Official Disability Guidelines do not recommend the use of repeat imaging unless there has been a significant change in clinical presentation or a suspicion of change in pathology. Although it is noted that the patient has had an increase in back pain, there is no documentation that the patient has had any recent conservative treatment. As there is no documentation of recent conservative treatment and there has not been a significant change in the patient's clinical presentation, the need for additional imaging studies is not supported. As such, the request for one (1) x-ray of the thoracic spine is not medically necessary or appropriate.

one (1) x-ray of the lumbar spine: 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): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Radiography.

Decision rationale: The ACOEM guidelines do not support radiographic imaging in the absence of red flag symptoms for serious spinal pathology unless the physician believes it would aid in treatment planning. The clinical documentation submitted for review does provide evidence that the physician is ordering the radiographic studies to support the need for an epidural steroid injection. However, the Official Disability Guidelines do not recommend the use of repeat imaging unless there has been a significant change in clinical presentation or a suspicion of change in pathology. Although it is noted that the patient has had an increase in back pain, there is no documentation that the patient has had any recent conservative treatment. As there is no documentation of recent conservative treatment and there has not been a significant change in the patient's clinical presentation, the need for additional imaging studies is not supported. As such, the request one (1) x-ray of the lumbar spine is not medically necessary or appropriate.

Aqua Therapy for the neck, back and bilateral upper extremities, 2-3 times per week for one (1) month: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy and Physical Medicine Sections Page(s): 22, 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Preface, Physical Therapy.

Decision rationale: The California MTUS recommends aquatic therapy for patients who would benefit from nonweightbearing during participation in an active therapy program. The clinical documentation submitted for review does indicate that the patient has bilateral lower extremities osteoarthritis in multiple lower extremity joints and would benefit from a nonweightbearing status. However, the Official Disability Guidelines recommend a 6 visit clinical trial to support the efficacy of this treatment modality. As the clinical documentation indicates that the patient has not had any physical therapy for a significant period of time, a clinical trial would be appropriate for this patient. The requested 2 to 3 times a week for a month exceeds this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested aqua therapy for the neck, back, bilateral upper extremities 2 to 3 times per week for one (1) month is not medically necessary or appropriate.