

<b>Case Number:</b>	CM13-0044475		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/16/2008
<b>Decision Date:</b>	02/27/2014	<b>UR Denial Date:</b>	10/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 Physical Medicine and Rehabilitation 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 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 49-year-old male who reported injury on 04/16/2008. The mechanism of injury was stated to be the patient was stacking boxes by hand which weighed approximately 80 pounds and felt pain. The patient was noted to undergo a posterior Gill laminectomy at L3-L4, a bilateral facetectomy and foraminotomy as well as posterolateral arthrosis and instrumentation at L3-L4 along with removal of hardware at L4, L5 and S1 and in exploration of the fusion at L3;4, L4,5 and L5-S1 on 05/10/2013. The patient was noted to have pain with flexion and extension. The patient was noted to have a positive bilateral straight leg raise at 50 degrees. The patient was noted to have lumbar spine pain and discomfort as well as a positive left and bilateral Braggard's and Goldthwait's as well as a Milgram test. The patient was noted to have tight hamstrings and hip flexors. The sitting root test of the left leg and right leg were positive at 75 degrees. The patient's motor strength was noted to be normal. The patient was noted to have decreased Achilles deep tendon reflexes on the right side and diminished bilateral patellar deep tendon reflexes. The patient was noted to have an MRI of the lumbar spine on 11/20/2011. The patient's diagnoses were noted to include chronic sprain/strain of the lumbar spine with underline degenerative disc pathology post-operative fusion, cervical spine sprain/strain with underlying disc pathologies, sprain/strain of the thoracic spine with degenerative arthritic changes and multiple central discs protrusions, anxiety and depression. The request was made for chiropractic care 2 times a week for 5 weeks, a pain management consult, an orthopedic surgical consult for the cervical spine and an MRI of the lumbar spine per the physician submitted request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic visits two (2) times a week for five (5) weeks: 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 Manual Therapy and Manipulation Section Page(s): 58-59.

**Decision rationale:** The California MTUS states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment beyond 4-6 visits should be documented with objective improvement in function. The patient was noted to have had a lumbar surgery on 05/10/2013 for a removal of hardware from the lumbar spine. The patient was noted to have had increased low back tenderness and swelling since the surgery, as well as a tightness and soreness. Clinical documentation submitted for review failed to provide the necessity for 10 sessions to exceed the guideline recommendations of 6 initial visits. Given the above and the lack of documentation of exceptional factors, the request for chiropractic visit 2 times a week for 5 weeks is not medically necessary.

**Pain management consult for the lumbar spine: 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 Ongoing Management Section Page(s): 78.

**Decision rationale:** The California MTUS recommends the consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Clinical documentation submitted for review failed to indicate what medications the patient was on to support the necessity for the referral. Given the above, the request for pain management consult for the lumbar spine is not medically necessary.

**Orthopedic consult for the cervical spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179.

**Decision rationale:** The California ACOEM Guidelines indicate a referral for a surgical consultation is indicated in patients who have persistent, severe and disabling shoulder or arm symptoms, activity limitations for more than 1 month or with extreme progression of symptoms, clear clinical imaging and electrophysiological evidence consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short and long term and unresolved radicular symptoms after receiving conservative treatment. Clinical documentation submitted for review indicated the patient had decreased range of motion in the neck and positive bilateral SDT greater on the left side and a positive FC test. The patient was noted to have an MRI of the cervical spine which revealed at C5-C6 a 3 mm left foraminal disc protrusion with abutment of the exiting nerve. And at C6-C7, there was noted to be a 4 mm left foraminal disc protrusion with abutment of the exiting left cervical nerve root. Clinical documentation submitted for review indicated the patient had objective findings upon examination. However, there was a lack of documentation of the official report for the MRI of the cervical spine to support the necessity for the evaluation. There was a lack of documentation of the dates of service, efficacy, and duration of physical therapy or conservative care for the cervical spine. Given the above, the request for orthopedic consult for the cervical spine is not medically necessary.

**Post operative MRI:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

**Decision rationale:** Repeat MRI's is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, and recurrent disc herniation). Official Disability Guidelines recommend a repeat MRI if the patient has a significant change in symptoms and/or finding suggestive of a significant pathology. Clinical documentation submitted for review indicated the physician was requesting authorization for a post-operative MRI of the lumbar spine. However, there was lack of documentation indicating the necessity for the requested service. Given the above, the request for postoperative MRI of the lumbar spine is not medically necessary.