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| Case Number: | CM13-0063064 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 03/08/2008 |
| Decision Date: | 04/15/2014 | UR Denial Date: | 12/03/2013 |
| Priority: | Standard | Application Received: | 12/09/2013 |

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 Family Practice 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:

The patient is a 39-year-old female who reported an injury on 03/08/2008. The most recent clinical documentation provided for review was from 08/27/2013 which stated the patient has been out of prescribed pain medications with only Percocet helping. The patient had no effect from tramadol or Norco use. The patient hurts but feels improved in range of motion, with some pain in the right leg but less than before. Two weeks prior to the examination, the patient had a lump on the right wrist, with hand cramps, with pain shooting into the right shoulder. Objectively, the patient's lumbar spine range of motion was decreased in all ranges with forward flexion of 20 degrees, extension 50 degrees, and left lateral flexion at 10 degrees. The right wrist had visible palpable edema on the dorsum of the right wrist. The treatment plan was for the patient to utilize a wrist brace, have a sonogram (of an unknown/illegible body part). This is to rule out tendonitis versus cystic mass due to using walker and a 4 pronged cane. The patient was also recommended for a Toradol injection 2 ml (30 mg/ml), and renew Percocet with a rush order, and physical therapy for status post PLIF 3 times a week times 5 weeks for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT SCAN LUMBAR 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 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004)

Decision rationale: Under California MTUS/ACOEM, it states that imaging studies should be reserved for cases in which surgery is considered and red flag diagnoses are being evaluated. In the case of this patient, there is a lack of a comprehensive physical examination providing a thorough overview of the patient's lumbar spine. It was noted that the patient had undergone a previous lumbar fusion procedure several months prior; however, there are no focal neurologic findings reported on the current documentation. Without having a clear comprehensive clinical assessment or any red flag symptoms, the patient does not meet guideline criteria for a CT of the lumbar spine at this time. As such, the requested service is non-certified.

MRI LUMBAR 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 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004)

Decision rationale: Under California MTUS/ACOEM, it states that imaging studies should be reserved for cases in which surgery is considered and red flag diagnoses are being evaluated. In the case of this patient, there is a lack of a comprehensive physical examination providing a thorough overview of the patient's lumbar spine. It was noted that the patient had undergone a previous lumbar fusion procedure several months prior; however, there are no focal neurologic findings reported on the current documentation. Without having a clear comprehensive clinical assessment or any red flag symptoms, the patient does not meet guideline criteria for a MRI of the lumbar spine at this time. As such, the requested service is non-certified.

PHYSICAL THERAPY 15 VISITS FOR 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 Physical Medicine Page(s): 98-99.

Decision rationale: According to California MTUS Guidelines, active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. It further states that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. However, the most recent clinical documentation is from 08/2013. Without having a current comprehensive physical examination

providing a thorough overview of the patient's current pathology, the medical necessity for physical therapy cannot be established. As such, the requested service is not deemed medically necessary and is non-certified.

SONOGRAM RIGHT AND LEFT GLUTEUS: 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, Ultrasound, diagnostic (imaging)

Decision rationale: Under Official Disability Guidelines, it states that ultrasound for diagnostic purposes are not recommended. There is no published peer reviewed literature supporting the use of diagnostic ultrasound in the evaluation of patients with back pain or radicular symptoms. In the case of this patient, the purpose of the study is to rule out mass. However, there are no current examination findings indicating the right or left gluteus have been reviewed with suspected masses needing further diagnostic study. Without having a thorough comprehensive physical examination providing a complete rationale for the requested service, the request for sonogram of the right and left gluteus cannot be supported. As such, the requested service is non-certified.