MAXIMUS Federal Services

Case Number:	CM14-0002660		
Date Assigned:	01/29/2014	Date of Injury:	08/23/1999
Decision Date:	06/16/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/07/2014

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 Family Practice and is licensed to practice in Tennesee, Virginia, and 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 63 year old female injured on 08/23/99 due to a fall. Current diagnoses include right leg pain and radiculopathy. The patient is status post L4-5 and L5-S1 hemilaminotomy. Documentation indicates the patient has known chronic nerve damage and weak L5-S1 muscles with increasing complaints of pain and increasing weakness which has not responded to exercise and time. The patient has attempted physical therapy, TENS use, H-wave, and epidural steroid injections which provided minimal relief. Foot drop of the right lower extremity resulted in frequent trauma and abnormal toenail growth to the right lower extremity. Orthotics for foot drop of the right lower extremity were requested. Documentation indicates the patient utilizes MS IR for pain, Norco during the day for deep pain; however, does not decrease burning pain or spasms. Current medications include MS IR 15mg 2 BID, Robaxin 500mg QID, Baclofen 10mg 2 QHS, Zolpidem 5mg QHS, Norco 10/325mg BID, Elavil 10mg 3 HS, Klonopin 0.5mg QHS, Trazadone HS, and Flector patch Q 12 hours.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-RAY OF HIPS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip & Pelvis (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM) 2ND EDITION (2004), HIP AND GROIN DISORDERS - HIP PAIN, X-RAYS (ROENTGENOGRAMS),

Decision rationale: As noted in the Hip and Groin Disorders - Hip Pain chapter of the American College of Occupational and Environmental Medicine, X-rays are recommended for evaluating acute, subacute, or chronic hip pain. However, previous bilateral hip x-rays were obtained on 06/2008 with noted chronic tendonitis. There have been no noted injuries or falls to suspect acute injury that would necessitate additional diagnostic procedures. As such, the request for x-rays of the hips cannot be recommended as medically necessary.

MRI OF THE BACK WITH CONTRAST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section: Low Back Lumbar and Thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines-online version, Low Back Complaints, Magnetic Resonance Imaging (MRI).

Decision rationale: The most recent MRI of the lumbar spine was performed on 05/23/11. Repeat MRI 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, recurrent disc herniation). There is limited objective data to supported a worsening in the patient's status. As such, the request for MRI of the back with contrast cannot be recommended at this time.

PHYSICAL THERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines Current guidelines recommend the use of physical therapy for myalgia and myositis, neuralgia, neuritis, and radiculitis, and Reflex sympathetic dystrophy (CRPS). The documentation indicated the patient has previously attempted physical therapy over the last 14 years since her injury and has received no benefit. There is no documentation of exceptional factors that would support the need for therapy at this time. As such, the request for physical therapy cannot be recommended as medically necessary at this time.