MAXIMUS Federal Services

Case Number:	CM14-0006226		
Date Assigned:	03/03/2014	Date of Injury:	06/24/2002
Decision Date:	08/22/2014	UR Denial Date:	01/11/2014
Priority:	Standard	Application Received:	01/15/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 59 year old male with a work injury dated 6/27/02 after a fall out of a truck.The diagnoses include cervicalgia and lumbar sprain/strain. Under consideration is a request for x-rays of the cervical and lumbar spine and physical therapy lumbar and cervical spine x 8. There is a primary treating physician (PR-2) document dated. On physical exam there is decreased cervical range of motion. Neural foraminal compression test is negative bilaterally. There is no tenderness upon palpation. The lumbar exam reveals mildly positive tenderness in lower paralumbar region, right>left. There is sacroiliac tenderness and there is no scoliosis. There is normal upper and lower extremity muscle motor strength testing as well as normal sensation in all the dermatomes in the upper and lower extremities. There is negative straight leg raise testing in the seated position bilaterally and negative in the supine position to 90 degrees bilaterally. Gait was normal. There were normal upper and lower extremity reflexes. Heel and toe walking were normal. Lumbar x-rays dated 1/22/13 reveal no fracture, dislocation or malalignment. There is moderate disc space narrowing at L5-Sl. Lumbar x-rays dated 10/29/12 reveal that disc heights and alignment are preserved. There is moderate disc space narrowing at L5-S 1. Cervical MRI dated 5/06/2011 notes mild loss of disc height with mild annular bulging at C5-6 and C6-7. There are mild degenerative changes at C7-T1and a small central protrusion at T3-4. MRI of the lumbar spine report dated 7/01/2002 has been reviewed. At L5-S1 there is mild posterior disc bulging centrally with degenerative changes and mild narrowing. There is no nerve root impingement. The discussion/plan states that the provider recommends physical therapy but no surgery at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-RAYS OF THE CERVICAL SPINE AND LUMBAR 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.

Decision rationale: X-rays of the cervical and lumbar spine are not medically necessary per the MTUS guidelines. The MTUS ACOEM guidelines state that the criteria for ordering neck imaging studies are: emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction,failure to progress in a strengthening program intended to avoidSurgery. The MTUS ACOEM guidelines state that lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. The documentation submitted reveals no red flag issues, no new trauma, and no evidence that would necessitate cervical and lumbar x-rays. There is also no documentation of how lumbar x-rays or cervical x-rays would alter patient management. The request for x-rays of the cervical and lumbar spine are not medically necessary.

PHYSICAL THERAPY , LUMBAR SPINE AND CERVICAL SPINE X 8: 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 p.98-99 Page(s): 98-99.

Decision rationale: Physical therapy lumbar spine, cervical spine x 8 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient has had prior physical therapy without sustained benefit. Given the fact that the patient has not had significant benefit from prior therapy and should be versed in a home exercise program additional therapy cannot be certified. The request for physical therapy lumbar spine, cervical spine x 8 is not medically necessary.