

<b>Case Number:</b>	CM14-0106170		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	08/21/2012
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	07/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 40-year-old female with a 8/21/12 date of injury. At the time (5/20/14) of request for authorization for Outpatient repeat MRI of the lumbar spine and Physical therapy right knee 3 times 4, there is documentation of subjective (7/10 low back pain with right lower extremity symptoms and 5/10 right knee pain) and objective findings (tender lumbar spine, lumbar range of motion limited with pain, neurologically unchanged, and spasm of lumboparaspinal musculature decreased), current diagnoses (right lumbar radiculopathy secondary to L4-5 protrusion and right knee pain), and treatment to date (physical therapy, home exercises, activity modification, and medications (including Tramadol and Orphenadrine)). Medical report identifies most recent lumbar MRI is greater than one year old and rationale for repeat MRI is due to marked changes axial low back pain/lower extremity neurologic component compared to the most recent MRI lumbar spine. In addition, medical reports identify patient has completed at least 12 physical therapy sessions to date. Regarding Outpatient repeat MRI of the lumbar spine, there is no documentation of a diagnosis/condition for which a repeat study is indicated. Regarding Physical therapy right knee 3 times 4, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of physical therapy provided to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient repeat MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of right lumbar radiculopathy secondary to L4-5 protrusion and right knee pain. However, despite documentation of a rationale identifying most recent lumbar MRI greater than one year old and marked changes axial low back pain/lower extremity neurologic component compared to at time of most recent MRI lumbar spine and given documentation of subjective (7/10 low back pain with right lower extremity symptoms) and objective (tender lumbar spine, lumbar range of motion limited with pain, neurologically unchanged, and spasm of lumboparaspinal musculature decreased) findings, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for Outpatient repeat MRI of the lumbar spine is not medically necessary.

**Physical therapy right knee 3 times 4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Physical therapy.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or

improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of pain in joint not to exceed 9 visits over 9 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of right lumbar radiculopathy secondary to L4-5 protrusion and right knee pain. In addition, there is documentation of at least 12 physical therapy sessions completed to date, which exceeds guidelines. Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for physical therapy right knee 3 times 4 is not medically necessary.