

Case Number:	CM14-0133753		
Date Assigned:	08/25/2014	Date of Injury:	04/16/2004
Decision Date:	10/28/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/18/2014

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 Orthopedic Spine Surgeon and is licensed to practice in Texas. 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 injured worker is a 63-year-old female who reported an injury on 04/16/2004 due to an unknown mechanism of injury. The injured worker's treatment history included multiple surgical interventions with the most recent being a C6-T1 fusion in 07/2013. The injured worker's surgery was followed by postsurgical care to include physical therapy and a neck brace. It was noted that the injured worker's postoperative physical therapy had provided significant relief in symptoms. The injured worker was evaluated on 07/07/2014. It was documented that the injured worker had neck, mid back, and low back pain rated at a 7/10. It is noted that the injured worker has increasing tingling in both feet. It was noted that the injured worker had undergone x-rays on 06/04/2014 of the thoracic and lumbar spine that documented facet arthropathy and multilevel degenerative changes. Objective findings included decreased sensation in the bilateral C6 dermatomal distribution and decreased sensation in the L5-S1 dermatomal distribution with +4/5 motor strength in the bilateral lower extremities secondary to pain. The injured worker's diagnoses included exploration of fusion and revision at the C6-T1, ACDF to C3-T1, bilateral L5 spondylosis, bilateral knee arthralgia with internal derangement, bilateral shoulder subacromial impingement and bursitis, and chronic pain syndrome. The injured worker's treatment plan included additional physical therapy for the thoracic and low back and an MRI of the thoracic and lumbar spine. A Request for Authorization form was submitted on 07/22/2014 to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (Acute & Chronic) Procedure Summary Magnetic resonance imaging

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for MRI (magnetic resonance imaging) of the thoracic spine is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends imaging of the low back for patients who have radiculopathy that has failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker has a significant history for surgical repair of the thoracic spine. However, the clinical documentation does indicate that the injured worker has developed new pain in the mid back. The injured worker underwent x-rays that identified degenerative changes of the thoracic spine. The clinical documentation does not provide any evidence that the injured worker has had any conservative treatment specifically directed towards this type of injury. The clinical documentation supports that all physical therapy already participated in have been directed towards other body parts. As it appears, the injured worker has not had any physical therapy for the thoracic spine; an imaging study would not be supported in this clinical situation. As such, the request for MRI (magnetic resonance imaging) of the thoracic spine is not medically necessary or appropriate.

MRI (magnetic resonance imaging) of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (Acute & Chronic) Procedure Summary Magnetic resonance imaging

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for MRI (magnetic resonance imaging) of the lumbar spine is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend diagnostic imaging for patients who have evidence of radiculopathy that has failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker has developed symptoms of radiculopathy as there is decreased sensation in the L5-S1 distribution. However, the clinical documentation fails to provide any evidence that the injured worker has not responded to any conservative treatment directed towards the lumbar spine. The clinical documentation does indicate that the injured worker has undergone acupuncture treatments for the thoracic and lumbar spine. However, there is no documentation of an active therapeutic program to address the injured worker's pain complaints. Therefore, an imaging study would not be supported in this clinical situation. As such, the request for MRI (magnetic resonance imaging) of the lumbar spine is not medically necessary or appropriate.

Post-op physical therapy QTY: 18: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The request for Post-op physical therapy QTY: 18 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends 24 visits of physical therapy in the postsurgical management of a fusion surgery. The clinical documentation submitted for review does indicate that the injured worker underwent fusion surgery over a year ago. California Medical Treatment Utilization Schedule recommends a 6 month of physical medicine treatment period. The requested postoperative physical therapy falls outside of this treatment period. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the request for Post-op physical therapy QTY: 18 is not medically necessary or appropriate.