MAXIMUS Federal Services

Case Number:	CM14-0068976		
Date Assigned:	07/14/2014	Date of Injury:	12/13/2011
Decision Date:	10/10/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/13/2014

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 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 injured worker is a 24 year old male who sustained work-related injuries on December 13, 2011. The mechanism of injury was fall due to an electric shock while on the ladder and fixing a light fixture. Physical therapy notes dated August 1, 2013 documents that he complained of head pain rated at 6-10/10, neck pain rated at 5/10, and to a lesser degree low back pain. He also has pain in the left side of the head and in the back. Head pain was constant and pulsing and at times causes blurred vision. Neck pain was constant but not quite severe as head pain. He stated that walking caused increased pain and has difficulty sleeping. He stated that his neck pain extends to the upper trunk down to the entire spine. He also reported numbness, tingling, and cold sensation in both hands. Numbness was noted also in the last three digits of both hands. The physical therapy notes dated October 8, 2013 document that the treatment helped decreased pain and improve upper extremity functional mobility. He continued to have problems with sleep and numbness in both hands and blurred vision. Overall, he reported slow improvement. He rated his head pain as 7/10 and neck pain as 4/10 aggravated by sitting, standing, walking, and bending. The most recent medical records dated March 12, 2014 documents that the injured worker complained of neck pain rated at 7-8/10 which he described as throbbing. He also complained of left eye pain rated at 6/10 which was burning and continuous. Pain would radiate from the left side of the face. He also complained of right knee pain rated at 6/10 and described it as continuous. Cervical spine range of motion was limited in all planes. Special cervical spine orthopedic tests were positive on the left. A left shoulder examination noted limited range of motion in all planes. A special shoulder orthopedic test was positive. Thoracolumbar range of motion was limited in all planes. Straight leg raising test and heel-toe walk test were positive, bilaterally. Upper extremity motor testing was 3-4/5 while hyperalgesia was noted at the C5, C6,

and C8. Lower extremity reflex was and motor testing was 4/5. He is diagnosed with (a) status post cerebral Chiari malformation surgery; and (b) lumbar spine chronic pain syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: According to evidence-based guidelines, lumbar magnetic resonance imaging (MRI) scans are warranted if there are unequivocal objective findings that identify specific nerve compromise on the neurological examination. Based on the most recent documented objective findings dated March 12, 2014, there is no evidence of radiculopathy or progressive neurological changes. He is also not a candidate for low back surgery. Therefore, the medical necessity of the requested lumbar magnetic resonance imaging (MRI) scan is not established.

Additional Physical Therapy Two Times A Week For Six Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Based on the provided records, the injured worker had prior 16 physical therapy sessions but provided no significant changes in levels of pain or there is no evidence of functional improvement. Evidence-based guidelines indicate that additional physical therapy sessions can be provided if there is documentation of a significant decrease in pain levels and significant functional improvements. Due to the absence of the said requisites, the medical necessity of the requested additional physical therapy two times a week for six weeks is not established. Therefore, this request is not medically necessary.