

Case Number:	CM14-0181610		
Date Assigned:	11/06/2014	Date of Injury:	11/10/2013
Decision Date:	01/16/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	10/31/2014

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 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:

The patient is a 21 year old female with an injury date of 11/10/13. Per the 10/31/14 and 10/03/14 reports the patient presents with lower back pain with recurrent muscle spasm at the right lower leg as well as right hip pain. Pain radiates down to the right lower extremity. The patient is working with modified duty. Examination of the lumbar spine reveals excessive lordosis with restricted range of motion. On palpation paravertebral muscle spasm is noted on the right side with lumbar facet loading and straight leg raise positive on the right. There is decreased sensation to light touch over the anterior thigh and L4, L5 lower extremity dermatomes on the right side. Tenderness is noted over the trochanter of the right hip with positive Faber test. The patient's diagnoses include: 1. Lumbar radiculopathy 2. Lumbar facet syndrome 3. Lower back pain 4. Hip pain 5. Hip bursitis Current medications are listed as Ibuprofen and Lidoderm patches. The utilization review being challenged is dated 10/30/14. The rationale regarding MRI lumbar spine is that there is a concurrent request for right greater trochanteric bursa injection and that the outcome of this injection should be addressed prior to determining the necessity of MRI. Two reports were provided dated 10/03/14 and 10/31/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), updated 08/22/2014

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI

Decision rationale: The patient presents with "lower back pain radiating to the right lower extremity" with recurrent muscle spasms at the right lower leg as well as right hip pain. The provider requests for MRI of the lumbar spine per 10/31/14 report. ODG, Low Back Chapter, MRI Topic, states that, "MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. 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)." The 10/31/14 report states consideration will be given to TFESI at the right L4-L5 for this patient and imaging studies are requested to rule out intraspinal pathology. The provider states, ""We will order MRI of the lumbar spine to assess anatomic pathology given the patient's clinical symptoms and objective findings on physical examination." The provider is also requesting for EMG/NCV studies of the right lower extremity to rule out lumbar spine radiculopathy vs. peripheral nerve entrapment. In this case, the patient has "lower back pain with radicular symptoms" along with positive "straight leg raise" on the right and "decreased sensation to light touch over the anterior thigh and the L4, L5 dermatomes." The reports state there is an 11/20/13 x-ray lumbar negative plain film. There is no evidence of a prior MRI lumbar for the patient or prior surgery. Radicular symptoms confirmed by examination and no prior MRI support that the request is medically necessary.

Physical therapy 2 times a week for 6 weeks for the lumbar spine and right hip: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), updated 08/22/2014

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

Decision rationale: The patient presents with lower back pain radiating to the right lower extremity with recurrent muscle spasms at the right lower leg as well as right hip pain. The provider requests for physical therapy 2 times a week for 6 weeks for the lumbar spine and right hip per 10/31/14 report. MTUS pages 98, 99 states that for Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis and radiculitis, 8-10 visits are recommended. The provider does not discuss the reason for this request. The provider cites the utilization review denial rationale regarding 24 prior physical therapy sessions and awaiting completion of the right trochanteric bursa injection. The provider also states the patient is

encouraged to continue her prior home exercise program. Prior therapy history is limited including dates of treatment as only two treatment reports are provided. There is no evidence the patient is within a post-surgical treatment period. In this case, it is not clear why additional therapy is needed for this patient at this time or why the home exercise program is not adequate. As of the most recent report, the right hip injection is only scheduled and the results of treatment are not known. Furthermore, the requested 12 sessions exceed what is allowed by MTUS. The request is not medically necessary.