

Case Number:	CM15-0132764		
Date Assigned:	08/06/2015	Date of Injury:	02/21/2011
Decision Date:	09/09/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

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 was a 45 year old male, who sustained an industrial injury, February 21, 2011. The injured worker previously received the following treatments prednisone taper dose, 3 sessions of physical therapy, Norco, Cyclobenzaprine, Flector Patches, and Neurontin, low back disc surgery, lumbar microdiscectomy, prednisone, topical analgesics, Percocet, Ibuprofen, heat patches and lumbar spine MRI. The injured worker was diagnosed with lumbar radiculopathy, sacroiliac pain and lumbar fusion of L5-S1. According to progress note of June 22, 2015, the injured worker's chief complaint was back pain with right lateral calf cramping and direct dermatomal line pain, which was stabbing. The injured worker also complained of muscle aches. The physical exam noted right and left heel and toe walks were completed without difficulty. The straight leg raises were negative bilaterally at 90 degrees. There was no pain with range of motion with the right and left lower extremities. There was decrease strength of the dorsal flexors on the right and the left of 4 out of 5. The ankle extension was 4 out of 5 on the left and the right. There was atrophy of the right calf. The treatment plan included physical therapy and a MRI with and without contrast of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy (therapeutic exercises times 12), (Re-learning neuromuscular movement times 6), (manual therapy techniques times 6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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, Physical Therapy.

Decision rationale: Regarding the request for Physical therapy (therapeutic exercises times 12), (Re-learning neuromuscular movement times 6), (manual therapy techniques times 6), Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested Physical therapy (therapeutic exercises times 12), (Re-learning neuromuscular movement times 6), (manual therapy techniques times 6) is not medically necessary.

MRI of the lumbar spine with and without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (http://odgtwc.com/odgtwc/low_back.htm#Radiography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRIs (magnetic resonance imaging).

Decision rationale: Regarding the request for MRI of the lumbar spine with and without contrast, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG states that MRIs are recommended for uncomplicated low back pain with radiculopathy after at least one month of conservative therapy. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Within the documentation available for review, there is no statement indicating what medical decision-making will be based upon the outcome of the currently requested MRI. Furthermore, there is no

documentation indicating how the patient's subjective complaints have changed since the time of the most recent MRI of the lumbar spine. In the absence of clarity regarding those issues, the currently requested MRI of the lumbar spine with and without contrast is not medically necessary.