

Case Number:	CM15-0192413		
Date Assigned:	10/06/2015	Date of Injury:	04/06/1998
Decision Date:	11/13/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	09/30/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 76 year old male who reported an industrial injury on 4-6-1998. His diagnoses, and or impressions, were noted to include lumbar degenerative disc disease, and lumbar 5- sacral 1 dis protrusion (per old MRI). No imaging studies were noted. His treatments were noted to include: a home exercise program with daily walking; medication management; and rest from work as he was noted to be retired. The progress notes of 9-14-2015 reported complaints which included: that he had not had magnetic resonance imaging or therapy in a long time; that he had more back pain recently and when it became severe, he had to lie down; that he was walking 5 miles-day which helped; that his pain increased with just sitting; and that he would like a refill of Hydrocodone for flare-ups of low back pain, that he had not had any refills in 3 months. The objective findings were noted to include: that therapy and occasional Hydrocodone had controlled his pain; lumbar spasms and tightness with straight leg raise; decreased Achilles, compared to patella, tendon reflex; flexion at the waist was 50 and extension on 10 degrees; and a review of his lumbar exercises. The physician's request for treatment was noted to include magnetic resonance imaging of the lumbar without contrast, and 6 physical therapy visits, 1 x 6. The Request for Authorization, dated 9-14-2015, was noted to include magnetic resonance imaging of the lumbar spine without contrast, and 6 physical therapy visits. The Utilization Review of 9-21-2015 non-certified the request for magnetic resonance imaging, without contrast, of the lumbar spine, and physical therapy for the lumbar spine, 1 x a week x 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI without contrast, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: 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 who 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. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.

Physical therapy once weekly for six weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Physical Medicine Guidelines-Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic

dystrophy (CRPS) (ICD9 337.2):24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no objective explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. The request is not medically necessary.