

<b>Case Number:</b>	CM15-0028158		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	10/15/2014
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/16/2015

### 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  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 38 year old female with an industrial injury dated 10/15/2014. The mechanism of injury is documented as a motor vehicle accident. She presented for follow up on 01/19/2015 with complaints of back, neck and leg pain. Range of motion of the neck was normal with pain. Lumbar range of motion was normal with pain. Straight leg raise test and FABER test were negative. Prior treatment included physical therapy and medications. Diagnoses included :Lumbago, Thoracic/Lumbosacral radiculitis, Disturbance of skin sensation, Pain in joint, lower leg, Chest pain unspecified On 02/06/2015 utilization review returned the following decisions: Flexion/Extension x-rays of the lumbar spine were denied. MTUS/ACOEM was cited. MRI of the left knee was denied. MTUS/ACOEM was cited. The request for continued physical therapy was modified to 2 sessions after the epidural steroid injection. ODG was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexion/extension x-rays of the lumbar spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Low Back Complaints, Imaging, pages 303-304.

**Decision rationale:** Per ACOEM Treatment Guidelines for the Lower Back Disorders states Criteria for ordering imaging studies such as the requested X-rays of the lumbar spine include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. Review of submitted medical reports have adequately demonstrated the indication for the Lumbar spine x-rays to support this imaging study as reports noted acute symptoms of ongoing pain post motor vehicle accident. The Flexion/extension x-rays of the lumbar spine is medically necessary and appropriate.

**MRI of the left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Knee, Diagnostic Imaging, page 341-343.

**Decision rationale:** There are no recent x-rays of the knee showing acute findings. Guidelines states that most knee problems improve quickly once any red-flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results). Submitted reports have not adequately demonstrated remarkable clinical findings, acute flare-up, new injuries, failed conservative treatment trial or progressive change to support for the imaging study. The MRI of the left knee is not medically necessary and appropriate.

**Physical Therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted

physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical Therapy is not medically necessary and appropriate.