

<b>Case Number:</b>	CM15-0029905		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	07/28/2014
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### 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, Hawaii  
 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 64 year old male who sustained an industrial related injury on 7/28/14. The injured worker had complaints of bilateral thumb pain, chronic cough, decreased hearing in the left ear, and low back pain that radiated to the left lower extremity. Diagnoses included bilateral thumb arthritis at the carpometacarpal joint and lumbar disc bulging at L5-S1 with left sided S1 radiculopathy. Treatment included physical therapy. The treating physician requested authorization for a MRI of the lumbar spine, ultrasound 3 times per week for the lumbar spine, massage 3 times per week for the lumbar spine, and additional physical therapy 3 times per week for the lumbar spine. On 1/29/15 the requests were non-certified. Regarding the MRI, the utilization review (UR) physician noted radicular findings should be noted to substantiate the need for a MRI of the lumbar spine. Therefore the request was non-certified. Regarding ultrasound, the UR physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted ultrasound is not supported for this clinical presentation. Regarding massage, the UR physician noted there needs to be a positive patient response to prior treatment. Therefore the request was non-certified. Regarding physical therapy, the UR physician cited the MTUS guidelines and noted the objective outcome, scope, and nature of prior physical therapy is not elaborated. Therefore the request was non-certified.

### 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.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter MRI.

**Decision rationale:** The patient presents with pain affecting the lumbar spine with associated radiating pain into the left lower extremity and right & left thumb. The current request is for MRI of the Lumbar Spine. The treating physician documents that the patient has had lumbar X-Rays and states, "Lumbar spine, disc space narrowing at L5-S1. Request authorization for MRI scan of the lumbar spine." The treating physician also documented tenderness to palpation and positive Lasegue's test on the left lower lumbar area. (36B) The ODG guidelines state, "Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit." In this case, the treating physician has documented that the patient has radiculopathy and that the patient has received physical therapy and medication for over a month. There is no documentation of prior MRI scans in the records provided. The current request is medically necessary and the recommendation is for authorization.

**Additional physical therapy 3 times a week for 4 weeks to the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy (PT).

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

**Decision rationale:** The patient presents with pain affecting the lumbar spine and right & left thumb. The current request is for Additional Physical Therapy 3 time a week for 4 weeks to the lumbar spine. The treating physician states that the patient has completed 8 visits of physical therapy for the lumbar spine. The physical therapist states, "Patient reports that he is doing better and physical therapy has helped decrease pain and increase motion. Feels he can move with less pain. Patient has increased tolerance to exercise and good gait. Recommended continue physical therapy 3 X 2 to resolve tightness then re-evaluate for potential discharge to home exercise program." (28B) The MTUS guidelines state, "They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process" and MTUS only allows 8-10 sessions of physical therapy. In this case, the treating physician has requested an amount which would exceed the recommended guidelines. The current request is not medically necessary and the recommendation is for denial.

**Flexeril 7.5mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42, 63-66.

**Decision rationale:** The patient presents with pain affecting the lumbar spine and right & left thumb. The current request is for Flexeril 7.5 mg #90. The treating physician states, "There is spasm about the left lower lumbar region. Flexeril 7.5 mg #90 for spasm." (33B) The MTUS guidelines state, "Recommended as an option, using a short course of therapy. Treatment should be brief." Utilization Review modified this request from #90 to #60. In this case, the treating physician has prescribed this medication for long term use. The MTUS guidelines only recommend this medication for short term therapy. The current request is not medically necessary and the recommendation is for denial.