

Case Number:	CM15-0225415		
Date Assigned:	11/23/2015	Date of Injury:	03/29/2010
Decision Date:	12/31/2015	UR Denial Date:	10/29/2015
Priority:	Standard	Application Received:	11/17/2015

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: 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:

The injured worker is a 44 year old male who sustained an industrial injury March 29, 2010. Past history included two level anterior lumbar interbody fusion L4-S1 July 2012. Past treatment included medication, two lumbar epidural injections, physical therapy, and medication. Diagnoses are history of head injury with epidural hemorrhage and craniotomy March 2010; cognitive difficulties secondary to head injury; lumbar spine disease; history of cervical strain. According to a physician's notes dated October 15, 2015, the injured worker presented for re-evaluation with complaints of continued low back pain with intermittent headaches. He has episodes of confusion and difficulty with memory, which are unchanged. Current medication included Norco, Gabapentin and Omeprazole. Objective findings included; alert and oriented to time, place and person, memory intact; cranial nerves II-XII intact; all muscle groups show 5 out of 5 strength; sensation intact to touch pinprick and vibration; gait normal including heel toe and tandem gait. Treatment plan included adjustments to medication, repeat MRI of the lumbar spine and referral to pain management for consideration of epidural injections. At issue, is the request for authorization dated October 20, 2015, for physical therapy and an MRI of the lumbar spine. Medical records indicated that physical therapy was ordered in December of 2014 and June of 2015. It is difficult to decipher how much physical therapy was received in the past year, based on the medical records provided. According to utilization review dated March 29, 2010, the requests for 18 sessions of Physical Therapy to the low back (3 x 6) and an MRI of the lumbar spine without contrast are non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 sessions of physical therapy to the low back (3x6): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical therapy guidelines.

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 goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The patient has already completed physical therapy. The request is in excess of these recommendations per the California MTUS. There is no objective reason why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions in the provided clinical documentation. Therefore, the request is not medically necessary.

MRI of the lumbar spine without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar.

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.