

Case Number:	CM15-0085510		
Date Assigned:	05/08/2015	Date of Injury:	04/10/2013
Decision Date:	06/11/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/05/2015

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: Emergency 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 is a 34-year-old female, with a reported date of injury of 04/10/2013. The diagnoses include low back pain, lumbar discopathy, right lower extremity radiculopathy versus right greater trochanteric bursitis, and lumbosacral strain. Treatments to date have included x-rays of the lumbar spine, intramuscular injection, electro diagnostic studies, and oral medications. There is a report of a prior electro diagnostic testing was negative but no date of exam or report was provided for review. MRI of lumbar spine dated 6/10/13 was normal. A lumbar X-ray was performed by provider on 3/25/15 and was reportedly normal. The progress report dated 03/25/2015 indicates that the injured worker had constant pain in the low back. There was radiation of pain into the right lower extremity. She rated her pain 7 out of 10. It was noted that there was intermittent pain in the hips, which was rated 5 out of 10. The physical examination of the low back showed tenderness to palpation of the paravertebral muscle with spasm, positive seated nerve root test, restricted range of motion, no clinical evidence of stability on exam, intact coordination and balance, tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as the foot. An examination of the hips showed tenderness in the posterolateral region and no pain with range of motion. The treating physician requested continued physical therapy for the lumbar spine and an MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued physical therapy (lumbar) 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine, passive therapy Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back.

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

Decision rationale: As per MTUS Chronic pain guidelines physical therapy is recommended for many situations with evidence showing improvement in function and pain. Maximum number of PT sessions recommended by guideline is 10 sessions with a trial of 6 before additional may be recommended. Patient has documented several prior PT sessions (Total number was not documented) was completed and had reported subjective improvement. The provider has failed to document any objective improvement from prior sessions, how many physical therapy sessions were completed or appropriate rationale as to why additional PT sessions are necessary. Objective improvement in strength or pain is not appropriately documented, only subjective belief in improvement. There is no documentation if patient is performing home-directed therapy with skills taught during PT sessions. There is no documentation as to why home directed therapy and exercise is not sufficient. Total number of requested sessions exceeds guideline recommendation. Documentation fails to support additional PT sessions. Additional 12 physical therapy sessions are not medically necessary.

Magnetic Resonance Imaging (MRI) of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), MRI, low back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304, 309.

Decision rationale: As per ACOEM Guidelines, imaging studies should be ordered in event of "red flag" signs of symptoms, signs of new neurologic dysfunction, clarification of anatomy prior to invasive procedure or failure to progress in therapy program. Patient does not meet any of these criteria. There are no documented red flag findings in complaints or exam. There is noted new neurologic dysfunction. This provider documented a similar claimed dermatomal sensory anomaly 1 year prior which is not present in any other physical exam by any other notes by other providers. There are no other findings consistent with radiculopathy. Patient has had an MRI done on 6/10/13 that was normal. There is no justification documented for why MRI of lumbar spine was needed. MRI of lumbar spine is not medically necessary.