MAXIMUS Federal Services

Case Number:	CM15-0100412		
Date Assigned:	06/02/2015	Date of Injury:	06/16/2011
Decision Date:	06/30/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/26/2015

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 58 year old female, who sustained an industrial injury on 06/16/2011. She reported injuring her lower back and leg. The injured worker is currently temporarily totally disabled. The injured worker is currently diagnosed as having lumbago, lumbar intervertebral disc displacement without myelopathy, and sciatica. Treatment and diagnostics to date has included electromyography/nerve conduction velocity studies which revealed right lumbar radiculopathy, lumbar spine MRI which revealed disc protrusion ad spinal stenosis, chiropractic treatment, physical therapy, epidural steroid injections, and medications. In a progress note dated 03/24/2015, the injured worker presented with complaints of low back pain with radiation to the right leg. Objective findings include limited range of motion to lumbar spine with tenderness and spasms. The treating physician reported requesting authorization for lumbar spine MRI and physical therapy for the low back.

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: Upheld

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 Imaging, pages 303-304.

Decision rationale: Per ACOEM Treatment Guidelines for the Lower Back Disorders, Criteria for ordering imaging studies 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, none identified here. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electro diagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports for this chronic injury have not adequately demonstrated the indication for repeating the MRI of the Lumbar spine nor document any specific changed clinical findings of neurological deficits, progressive deterioration, or acute red-flag findings to support repeating this imaging study. The patient exhibits continued chronic low back pain with unchanged clinical findings. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The MRI of the lumbar spine is not medically necessary and appropriate.

Physical therapy, twice weekly, low back Qty: 10.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine guidelines Page(s): 99.

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 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, twice weekly, low back Qty: 10.00 is not medically necessary and appropriate.