

Case Number:	CM15-0019545		
Date Assigned:	02/09/2015	Date of Injury:	06/24/2013
Decision Date:	03/25/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	02/02/2015

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: New York

Certification(s)/Specialty: Internal 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 55 year old female, who sustained an industrial injury reported on 6/24/2013. She has reported constant, radiating neck and low back pain. The diagnoses were noted to have included cervicgia; lumbago; and cervical and lumbar discopathy. Treatments to date have included consultations; diagnostic imaging studies; physical therapy; and medication management that. The most current work status classification, post the 12/2014 surgery, for this injured worker (IW) was not noted to have been at maximum medical improvement and back to work at full duty; as per the PR-2 dated 11/13/2014. On 11/18/2014, Utilization Review (UR) non-certified, for medical necessity, the request, made on 11/14/2014, for a single positional magnetic resonance imaging of the cervical spine; a single positional magnetic resonance imaging of the lumbar spine; and 8 physical therapy sessions for the cervical and lumbar spine. The Medical Treatment Utilization Schedule, chronic pain physical medicine guidelines, magnetic resonance imaging, cervical, thoracic, and lumbar spine, emergence of a red flag, physical therapy guidelines, were cited. The physician progress notes that included the treatment plan for the above request and UR, were not available for my review.

IMR ISSUES, DECISIONS AND RATIONALES

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

single positional MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Page(s): 304 (pdf format).

Decision rationale: There is no documentation provided necessitating a cervical MRI. MRI is indicated if there are unequivocal objective findings that identify specific nerve compromise on neurologic examination in patients who do not respond to treatment and who would consider surgical intervention. Cervical MRI imaging is the mainstay in the evaluation of myelopathy. In addition to diagnosing disc herniation, neoplastic or infectious pathology can be visualized. In this case , there is a history of cervical radiculopathy with physical exam evidence of motor and sensory changes in the bilateral C6-C7 dermatomes but no failure of rehabilitation, worsening neurologic deficits or proposed surgical intervention. Medical necessity for the requested cervical MRI has not been established. The requested service is not medically necessary.

single positional MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Page(s): 304 (pdf format).

Decision rationale: There is no documentation of any significant change in the claimant's symptoms or exam. He is maintained on medical therapy and there has been no new neurologic findings or subjective complaints of increased back pain, radiculopathy, or bowel and/or bladder incontinence. Per the documentation the claimant has sensory changes in the L5-S1 dermatomes. There is no reported consideration for any interventional procedures or surgery for the treatment of his chronic back condition. There is no specific indication for the requested MRI of the lumbar spine per CA MTUS Guidelines. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Physical Therapy visits for the cervical and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Page(s): 98 (pdf format).

Decision rationale: Per California MTUS Treatment Guidelines 2009, physical therapy is indicated for the treatment of chronic neck pain. Recommendations state that for most patients with more severe acute and subacute neck pain conditions 10 visits for radicular complaints is indicated as long as functional improvement and program progression are documented. Active

therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. In this case the claimant has completed 6 sessions of therapy without any reported functional improvement. There is no specific indication for additional therapy sessions. Medical necessity for the requested additional physical therapy sessions has not been established. The requested service is not medically necessary.