

<b>Case Number:</b>	CM15-0178863		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	03/18/2012
<b>Decision Date:</b>	10/29/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### 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 41 year old female, who sustained an industrial injury on 3-18-2012. Medical records indicate the worker is undergoing treatment for lumbar sprain/strain and lumbar interval disc displacement. A recent progress report dated 8-11-2015, reported the injured worker complained of lumbar pain. Physical examination revealed pain and spasm to palpation. Lumbar magnetic resonance imaging showed lumbar 4-5 posterior annular tear and 3mm disc protrusion at lumbar 5. Treatment to date has included physical therapy and medication management. The physician is requesting lumbar magnetic resonance imaging, Physical Therapy, Lumbar spine, 2 times weekly for 4 weeks, 8 sessions and Pain Medications (unclear-unspecified). On 8-19-2015, the Utilization Review noncertified the request for lumbar magnetic resonance imaging, Physical Therapy, Lumbar spine, 2 times weekly for 4 weeks, 8 sessions and Pain Medications (unclear-unspecified).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI (magnetic resonance imaging), Lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.  
Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic (Acute & Chronic) - MRI (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter under MRI's (magnetic resonance imaging) (L-spine).

**Decision rationale:** Based on the 08/11/15 progress report provided by treating physician, the patient presents with low back pain. The request is for MRI (magnetic resonance imaging), Lumbar spine. Patient's diagnosis per Request for Authorization form dated 07/13/15 includes lumbar spine intervertebral disc. Treatment to date has included acupuncture, chiropractic, trigger point therapy, electric muscle stimulation, vibratory massage, heat, ice and neuromuscular massage. The patient is permanent and stationary, per 08/11/15 report. ACOEM Guidelines, Low Back chapter 8, Special Studies, pages 177 and 178, state "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." ODG guidelines, Low back chapter under MRI's (magnetic resonance imaging) (L-spine) states that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG Guidelines do not support MRIs unless there are neurologic signs/symptoms present. "Repeat MRIs are indicated only if there has been progression of neurologic deficit." Treater has not provided medical rationale for the request. Physical examination to the lumbar spine on 08/11/15 revealed pain and spasm to palpation. The patient had MRI of the lumbar spine in 2012, per 07/13/15 report. In this case, there is no significant change in symptoms or examination findings to warrant a repeat MRI. MRI of the lumbar spine dated 07/24/15 showed posterior annular tear at L4-L5 and 3mm disc protrusion at L5. It appears that MRI was performed prior to authorization. According to guidelines, for an updated or repeat MRI, the patient must be post-operative or present with a new injury, red flags such as infection, tumor, fracture or neurologic progression. This patient does not present with any other condition to warrant another repeat MRI study. This request is not in accordance with guidelines. Therefore, the request IS/WAS NOT medically necessary.

**Physical Therapy, Lumbar spine, 2 times wkly for 4 wks, 8 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** Based on the 08/11/15 progress report provided by treating physician, the patient presents with low back pain. The request is for Physical Therapy, Lumbar spine, 2 times wkly for 4 wks, 8 sessions. Patient's diagnosis per Request for Authorization form dated 07/13/15 includes lumbar spine intervertebral disc. Physical examination to the lumbar spine on 08/11/15 revealed pain and spasm to palpation. MRI of the lumbar spine dated 07/24/15 showed posterior annular tear at L4-L5 and 3mm disc protrusion at L5. Treatment to date has included acupuncture, chiropractic, trigger point therapy, electric muscle stimulation, vibratory massage, heat, ice and neuromuscular massage. The patient is permanent and stationary, per 08/11/15 report. MTUS Physical Medicine Section, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. "Treater has not provided reason for the request. Given patient's diagnosis and continued pain, a short course of physical therapy

would appear to be indicated. However, treater has not provided a precise treatment history, documented efficacy of prior therapy, nor explained why on-going therapy is needed. The request for 8 additional sessions would exceed what is allowed by MTUS. Therefore, the request IS NOT medically necessary.

**Pain Medications (unclear/unspecified): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Section 4610.5 is added to the Labor Code.

**Decision rationale:** Based on the 08/11/15 progress report provided by treating physician, the patient presents with low back pain. The request is for Pain Medications (unclear/unspecified). Patient's diagnosis per Request for Authorization form dated 07/13/15 includes lumbar spine intervertebral disc. Physical examination to the lumbar spine on 08/11/15 revealed pain and spasm to palpation. MRI of the lumbar spine dated 07/24/15 showed posterior annular tear at L4-L5 and 3mm disc protrusion at L5. Treatment to date has included acupuncture, chiropractic, trigger point therapy, electric muscle stimulation, vibratory massage, heat, ice and neuromuscular massage. The patient is permanent and stationary, per 08/11/15 report. Section 4610.5 is added to the Labor Code, to read: (2) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition: (A) The guidelines adopted by the administrative director pursuant to Section 5307.27. (B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service. (C) Nationally recognized professional standards. (D) Expert opinion. (E) Generally accepted standards of medical practice. (F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious. Treater has not provided reason for the request, nor indicated medications being requested. A specific guideline cannot be cited because the requested service was not described in sufficient detail. In order to select the relevant guideline, the requested service must refer to a specific treatment, including the ingredients of the requested medications. The request in this case was too generic and might conceivably refer to any number of medical conditions and guideline citations. Medical necessity for the request cannot be established. Therefore, the request IS NOT medically necessary.