

Case Number:	CM14-0141649		
Date Assigned:	09/10/2014	Date of Injury:	04/08/2014
Decision Date:	10/16/2014	UR Denial Date:	08/06/2014
Priority:	Standard	Application Received:	09/02/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 56 year old female who had a work related injury on 04/08/14. The injured worker tripped on a groove in the cement and fell landing on both knees. The most recent clinical documentation submitted for review was dated 08/28/14 as a handwritten note complaining of cervical spine and lumbosacral spine discomfort. On physical examination there was decreased range of motion neck and low back. positive compression, straight leg raise. Diagnosis cervical spine disc herniation. Lumbosacral spine sprain/strain. Treatment rendered was physical therapy, x-ray/MRI sleep study internal medicine evaluation. X-ray of cervical spine dated 04/25/14 revealed severe loss of cervical spine curvature with phase two and three degenerative joint disease and disc space narrowing from C4 to C7. Cervical curve measured 6 degrees from the normal 43 degree lordotic curvature. The patient had hyperlordosis of the cervical spine x-ray of the lumbar spine revealed no listhesis. Normal lumbar lordosis. Normal range of motion. Moderate decreased disc height at L5-S1. Mineralization normal. Degenerative small bilateral superior and inferior endplate osteophytes seen at T12 through L4. Previous utilization review dated 08/06/14 noted that the injured worker had already completed therapy for two weeks, and 12 chiropractic visits. Additional 12 visits were recommended and certified. Prior utilization review on 08/06/14 non-certified. Current request was for eight physical therapy visits for neck and back. MRI of neck and back. Pain management consult. Internal medicine evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 physical therapy Visits for Neck/Back: Upheld

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

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

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 10 visits over 8 weeks for the treatment of lumbar strain/sprain and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. There is no documentation of exceptional factors that would support the need for therapy that exceeds guidelines either in duration of treatment or number of visits. The medical necessity of the physical therapy, lumbar spine quantity: 12.00 cannot be established at this time.

MRI Neck/Back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back Complaints, Magnetic Resonance Imaging (MRI).

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, MRI is not recommended in cases of uncomplicated low back pain, with radiculopathy, until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The clinical documentation fails to establish compelling objective data to substantiate the presence of radiculopathy or neurologic deficit. Additionally, there is no indication that the patient has undergone at least one month of conservative treatment. As such, the request for Magnetic Resonance Imaging (MRI) Lumbar Spine and cervical spine cannot be recommended as medically necessary.

Pain Management Consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines TWC Pain Procedure Summary 06/10/2014 Office Visits

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low back Complaints, Follow-up visits.

Decision rationale: There is no indication in the documentation that the patient has had a significant alteration in her status, acute injury, or requires treatment out of the scope of the

primary care provider. Additionally, the request did not specify the intent for referral and issues to be addressed. As such, the request for referral to pain management cannot be recommended as medically necessary.

Internal Medicine Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines TWC Pain Procedure Summary 06/10/2014 Office Visits

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines online version, Low back Complaints, Follow-up visits.

Decision rationale: There is no indication in the documentation that the patient has had a significant alteration in her status, acute injury, or requires treatment out of the scope of the primary care provider. Additionally, the request did not specify the intent for referral and issues to be addressed. As such, the request for referral for Internal Medicine Evaluation cannot be recommended as medically necessary at this time.