

Case Number:	CM13-0025426		
Date Assigned:	12/11/2013	Date of Injury:	03/06/2012
Decision Date:	06/05/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/17/2013

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 Occupational 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 patient is an employee of [REDACTED] and has submitted a claim for lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and right sacroiliac joint arthropathy associated with an industrial injury date of 03/06/2012. Treatment to date has included physical therapy, acupuncture, chiropractic care, and medications such as ibuprofen, cyclobenzaprine, and hydrocodone/apap. Medical records from 2012 to 2013 were reviewed showing that patient complained of low back pain graded 8/10 in severity radiating to the right leg. It was described as sharp and achy with associated numbness. Physical examination showed diffuse tenderness over the paralumbar muscles with facet tenderness from L4 to S1. Range of motion of the lumbar spine was restricted on all planes with presence of pain upon extension. Motor strength was graded 4/5 at right hip flexors, right knee extensors, and right big toe extensor. Provocative tests such as sacroiliac tenderness, Patrick's, sacroiliac thrust, and Yeoman's were positive at the right. Both Kemp's test and Farfan test were positive bilaterally. Deep tendon reflexes were equal and symmetric. Gait was antalgic to the right. Heel-toe walk resulted to exacerbated pain at the right. Sensation was diminished at right L4 and L5 dermatomes. MRI of the lumbar spine, dated 04/16/2012, revealed minimal disc bulges of 2mm at L1-L2 and L3-L4 and a 3mm disc bulge at L5-S1. There was also a 2-3mm disc bulge at L4-L5 and some evidence of multilevel facet arthrosis as well as some bilateral neuroforaminal stenosis. Utilization review from 09/09/2013 denied the requests for physical therapy 2 x 4 because there was no additional information as to the amount of therapy previously completed, the response to therapy, and the current deficits that would warrant additional treatment sessions; and lumbosacral brace because it is not recommended beyond the acute phase of back pain. On the other hand, the request for right L4-L5 and L5-S1 transforaminal epidural injections x 2 was modified into right L4-L5 and L5-S1

transforaminal epidural injection x 1 because the guidelines do not recommend a repeat ESI without an initial assessment of outcome of the previous one.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2X4: Upheld

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

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

Decision rationale: As stated on pages 98-99 of the California MTUS, Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, the patient already underwent previous physical therapy sessions, however, the total number of visits is unknown due to lack of documentation. There is no evidence stating the functional improvements that the patient has gained from it. Moreover, the request does not specify the body part to be treated. Therefore, the request for physical therapy 2 x 4 is not medically necessary and appropriate.

LUMBOSACRAL BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Work Loss Data Institute, LLC, Corpus Christi, Tx; www.odg-twc.com: Section: Low Back; as well as CA MTUS 9792.24.2 Chronic Pain Medical Treatment Guidelines, California Code of Regulations, Title 8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: As stated in the CA MTUS reference to ACOEM, Low Back Chapter, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In this case, the patient has been complaining of chronic back pain associated with an industrial injury date of 03/06/2012. Medical records submitted and reviewed do not indicate that the employee has acute exacerbation of back pain; thus, the request for a back brace as part of the conservative treatment regimen is outside the initial acute phase of injury and not supported by the guidelines. Therefore, the request for a lumbosacral brace is not medically necessary.