

<b>Case Number:</b>	CM13-0066526		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	06/05/2010
<b>Decision Date:</b>	04/15/2014	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2013

### 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 Physical Medicine and Rehabilitation, 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 a 55-year-old male who was injured on 06/08/2010 while he was pulling a hose and tripped on the carpet. The treatment history included physical therapy, epidural steroid injections 01/13/2012, and left L3-4 transforaminal epidural steroid injection (TFESI) on 08/16/2010. On 12/08/2013, medications include: Cymbalta 30 mg, Amitriptyline HCl 25 mg, Naproxen 500 mg tablet, Norco 5 mg/325 mg, and Tizanidine HCl 4 mg. Diagnostic studies reviewed include MRI (magnetic resonance imaging) of lumbar spine from 06/17/2010 revealed multilevel discogenic degeneration, focal left posterior disc extrusion with inferior migration in the lateral recess; foraminal narrowing that is moderate on the right L4-5 and moderately severe on the right at L5-S1. Interdisciplinary assessment dated 08/06/2013 revealed pain in his bilateral upper extremities, upper to lower back, right knee and left lower extremity. The patient describes pain medication and exercise program as improving his condition. In addition, he describes physical therapy as having worsened his condition. The patient's pain was described as 6/10 on a 10-point scale. He reported that the pain may increase to a 10 at worst on the same 10-point scale. He notes that his pain is present 90% to 100% of the time. In terms of activities of daily living, he notes that no assistance is needed for bathing, dressing and grooming. The patient describes some loss of social activity with his family and friends, as well as a complete loss of social activity with his spouse and wit recreational activity. Objective findings on exam revealed the patient moves about antalgically favoring his left leg. He has decreased sensation through the left leg in sciatic distribution. He does have slight weakness in flexion at the ankle. His reflexes are 2+ and equal. He has prominent myofascial restrictions in the lumbar and gluteal region on the left side. He does have some restriction on the right side compensatory. We recommend a total of 6 weeks part day treatment in the [REDACTED] program for this patient, based on his ability to demonstrate progress. Integrative Summary Report dated 11/15/2013 indicated

the patient is diagnosed with left L5-S1 lumbar radiculopathy, myofascial pain, depression with anxious features, and highly motivated. The recommendation for this patient is interdisciplinary reassessment in 4 months to determine appropriate recommendations. The following equipment was also recommended; stretch out strap and Thera Cane.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **INTERDISCIPLINARY REASSESSMENT - 1 VISIT, 4 HOURS APPROPRIATE.:**

Overtured

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 107 & 114, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs Page(s): 30-32.

**Decision rationale:** As per CA MTUS guidelines regarding interdisciplinary rehab programs, "the following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioids use; and (9) pretreatment levels of pain." In this case, this patient has chronic lower back pain and has been diagnosed with depression with anxiety. He has not returned to work since the injury and is highly motivated. He was treated and failed prior trial of conservative care and does not wish to have surgery. There is a prior interdisciplinary assessment done on 08/06/2013 and was determine to be a candidate for [REDACTED] program for total of 6 weeks. The above noted negative predictors were ruled out and hence the request is certified.

#### **STRETCH OUT STRAP PURCHASE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: National Library of Medicine and National Guideline Clearinghouse.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Extension Exercise Equipment.

**Decision rationale:** The CA MTUS guidelines do not discuss the issue in dispute and hence Official Disability Guidelines (ODG) have been consulted. The medical records submitted indicate that the provider requested stretch out strap to assist in home exercise program. However, there is no documentation of any specific plan or goals for the requested exercise equipment. There is no objective data to support the exercise equipment and the requested

treatment has not been shown to be related to a functional restoration program. Furthermore, there are no peer-reviewed evidence based trials of this device. Thus, the request for a standard stretch out strap is not medically necessary and appropriate.

**THERO-CANE PURCHASE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: National Library of Medicine and National Guideline.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Extension Exercise Equipment.

**Decision rationale:** The CA MTUS guidelines do not discuss the issue in dispute and hence Official Disability Guidelines (ODG) have been consulted. The medical records submitted indicate that the provider requested stretch out strap to assist in home exercise program. However, there is no documentation of any specific plan or goals for the requested exercise equipment. There is no objective data to support the exercise equipment and the requested treatment has not been shown to be related to a functional restoration program. Furthermore, there are no peer-reviewed evidence based trials of this device. Thus, the request for a standard stretch out strap is not medically necessary and appropriate.