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| Case Number: | CM14-0133947 | | |
| Date Assigned: | 08/27/2014 | Date of Injury: | 02/17/2006 |
| Decision Date: | 10/03/2014 | UR Denial Date: | 07/22/2014 |
| Priority: | Standard | Application Received: | 08/18/2014 |

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 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:

Patient is a 55 year-old male with date of injury 02/17/2006. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 06/25/2014, lists subjective complaints as pain in the low back. Objective findings: Examination of the lumbar spine revealed tenderness to palpation over the L3 to S1 and bilateral sacroiliac joints. Range of motion was restricted in all planes. Straight leg test was positive bilaterally. Faber, Hibb's, Gaenslen's, sacroiliac compression and Yeoman's were all positive bilaterally. Sensory examination in the lower extremity (LE) was intact in all dermatomes bilaterally. Diagnosis: 1. Disc herniation L3-4 with severe neural foraminal stenosis 2. Anterior posterior fusion at L4-5 and L5-S1 with residual low back pain 3. Sexual dysfunction 4. Status post right wrist open reduction internal fixation with chronic pain 5. Bilateral sacroiliitis 6. Facet arthropathy at L3-4 bilaterally with facet syndrome 7. Multiple trigger points at L3-S1 bilaterally 8. Chronic pain syndrome 9. Left L3-4 radiculopathy 10. Failed back surgery syndrome 11. Anxiety, depression 12. Neuropathic pain of the bilateral lower extremities 13. Myofascial pain with musculoskeletal spasm. Patient is status post-surgery for a right wrist fracture on 02/27/2006, status post anterior-posterior L4-5 and L5-S1 fusion on 05/17/2007, status post hardware removal at the wrist in January 2008, hardware removal at with microdiscectomy at L3-4 and interlaminar laminotomy performed 02/20/2012, and status post left sided L3-4 revision decompression 09/04/2013. Patient has completed 24 sessions of physical therapy since January of 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial Branch blocks L3-L4 facet joints to include the L2 and L3 medial branches bilaterally: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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), Facet joint medial branch blocks (therapeutic injections)

Decision rationale: The patient has had multiple surgeries, and there is no surgery planned at this time. According to the Official Disability Guidelines, facet joint medial branch blocks are not recommended except as a diagnostic tool. There is minimal evidence to support their use as treatment.

Percutaneous stimulation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Percutaneous electrical nerve stimulation (PENS)

Decision rationale: The Official Disability Guidelines do not recommend percutaneous electrical nerve stimulation as a primary treatment modality but a trial may be considered if used as an adjunct to a program of evidence-based functional restoration after other non-surgical treatments, including therapeutic exercise and transcutaneous electrical nerve stimulation (TENS), have been tried and failed or are judged to be unsuitable or contraindicated. There is a lack of high quality evidence to prove long-term efficacy. There is no documentation that other modalities have failed or have been judged to be unsuitable or contraindicated. The medical record does not support trial of a percutaneous electrical nerve stimulation unit.

Physical Therapy to the lumbar spine 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that 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. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. In addition, California Labor

Code Section 4604.5(c) (1) states that an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury. The medical record indicates that the patient has previously undergone 24 sessions of physical therapy. During the previous physical therapy sessions, the patient should have been taught exercises which are to be continued at home as directed by MTUS.

Physical Therapy to the lower extremities 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that 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. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. In addition, California Labor Code Section 4604.5(c) (1) states that an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury. The medical record indicates that the patient has previously undergone 24 sessions of physical therapy. During the previous physical therapy sessions, the patient should have been taught exercises which are to be continued at home as directed by MTUS.