

<b>Case Number:</b>	CM14-0166141		
<b>Date Assigned:</b>	10/13/2014	<b>Date of Injury:</b>	02/08/2013
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	09/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2014

### 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:

There were 121 pages provided for this review. The application for independent medical review was signed on October 6, 2014. It was pertaining to a request for an MRI of the lumbar spine, physical therapy three times a week for six weeks for the lumbar spine, and then reevaluation in six weeks. There was a review of the requests dated September 25, 2014. The claimant was born on February 28, 1978. His date of injury was February 8, 2013. The diagnosis was a lumbar disc protrusion. As of September 15, 2014, there was a suggestion in the notes of constant, moderate radiating pain radiating to the right to the shoulder area. The PR-2 however was in part not legible. The patient was felt to have a lumbar disc protrusion and a lumbar strain. There was planning for a repeat lumbar MRI. The prior MRI from December 20, 2013 showed disc desiccation at L4-L5 as well as multilevel degenerative changes and also disc protrusions at L4-L5 and L5-S1 with potential encroachment of the left L4 and L5 exiting nerve roots. The repeat MRI was not approved because there was no objective, documented progression of neurological deficit. There was also no rationale for additional supervised therapy. There were various PR-2 noted that mentioned diagnoses of lumbar sprain- strain. In other notes, he is described as a 35-year-old male who was injured on February 8, 2013 with low back pain with pain radiating to his right testicle. He was going to lift a boxes that weighed in total about 50 pounds. He bent over and as he lifted the boxes, he felt a sharp pain in his back. The note from February 4, 2014 notes that 22 sessions of therapy were rendered. The functional improvement outcomes are not noted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** Under MTUS/ACOEM, although there is subjective information presented in regarding increasing pain, there are little accompanying physical signs. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note 'Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study.' The guides warn that indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. I did not find electrodiagnostic studies. It can be said that ACOEM is intended for more acute injuries; therefore other evidence-based guides were also examined. The ODG guidelines note, in the Low Back Procedures section:- Lumbar spine trauma: trauma, neurological deficit- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)- Uncomplicated low back pain, suspicion of cancer, infection- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) - Uncomplicated low back pain, prior lumbar surgery- Uncomplicated low back pain, cauda equina syndrome There are no progressive neurologic signs. These criteria are also not met in this case. The request was appropriately considered not medically necessary under the MTUS and other evidence-based criteria.

**Physical therapy three (3) times six (6) for the lumbar spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 9792.26 Page(s): 98.

**Decision rationale:** The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. Also, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM

guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite:1. Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general.2. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request for physical therapy three (3) times six (6) for the lumbar spine is considered not medically necessary.