

Case Number:	CM14-0173975		
Date Assigned:	10/27/2014	Date of Injury:	10/09/2011
Decision Date:	12/04/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/22/2014

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 Family 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:

This is a 26 years old female patient who sustained a work related injury on 10/9/2011. The patient sustained the injury when she was pulling and pushing patient bed through the hospital she injured lower back. Current diagnoses include lumbago, Sciatica and lumbar disc displacement with myelopathy. Per the doctor's note dated 8/27/14, patient has complaints of constant moderate to, severe low back pain that was radiating to buttocks with numbness. Physical examination revealed spasm and tenderness to the bilateral lumbar paraspinal muscles. Per the doctor's note dated 6/05/14, patient has complaints of constant moderate to, severe low back pain. Per the doctor's note dated 5/09/14, patient has complaints of constant moderate to, severe low back pain that was radiating to buttocks with numbness. Physical examination revealed decreased ROM and ADL'S, spasm and tenderness from L5-S1, limited ROM, positive Kemp's test, straight legraise test, Yeoman's test, and Hibb's test bilaterally, decreased reflexes and normal sensory and motor examination. She has had FCE on 9/4/14 that revealed she was at a Light PDL. The current medication lists include Norco. The patient has had EMG on 6/13/14 that was normal; X-ray and MRI of her back. She had received Dolotin injection. She has had a urine drug toxicology report on 6/18/14. The patient has received 12 PT visits for this injury. The patient has used a lumbarpillow for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Work hardening/conditioning x 10 visits to the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning Page(s): 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125-126.

Decision rationale: Per the CA MTUS guidelines cited below, criteria for work hardening/conditioning include:(1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA). (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning.... (5) A defined return to work goal agreed to by the employer & employee:...(9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities." A work-related musculoskeletal deficit with the addition of evidence of physical, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands was not specified in the records provided. The medical records submitted did not provide documentation regarding a specific defined return-to-work goal or job plan that has been established, communicated and documented. There was no documentation provided for review that the patient failed a return to work program with modification. Per the records provided, the patient has received 12 PT visits for this injury. There are no complete therapy progress reports that objectively document the clinical and functional response of the patient from the previously rendered sessions. As cited below, there should be an evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Any such type of evidence is not specified in the records provided. Previous PT visit notes are not specified in the records provided. The request for Work hardening/conditioning x 10 visits to the lumbar spine is not medically necessary for this patient.