

<b>Case Number:</b>	CM14-0085901		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	10/26/2010
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in Nevada. 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 records presented for review indicate that this 50 year-old individual was injured on 10/26/10. The mechanism of injury is not listed in the records reviewed. The most recent progress note, dated 5/8/14, indicates that there are ongoing complaints of low back pain that radiates into the left lower extremity and right sacroiliac joint. The physical examination demonstrated lumbar spine: decrease lumbar lordosis, positive tenderness to palpation over the lumbar paravertebral musculature with a set tenderness at L4-S1. There was piriformis tenderness on the right, sacroiliac tenderness on the right, positive Patrick's test, sacroiliac thrust test and Yeoman's test. There was a positive Kemps test bilaterally. There was a positive straight leg raise seated right side 70 , left side 60, supine right side 60, and left side 50. There was a positive Farfan test bilaterally. There was decreased range of motion with pain. There was positive tenderness to palpation in the knees at the bilateral medial/lateral joint lines, left greater than right, as well as decreased flexion bilaterally. There was positive McMurray's test bilaterally. Sensation to pain, temperature, light touch, vibration, and 2-point discrimination is decreased along the left L2, L3, L5, and S1 dermatome. No recent diagnostic studies are available for review. Previous treatment includes epidural steroid injections, physical therapy, and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L5-S1 and Left S1 Transforaminal Epidural Steroid Injection: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**Decision rationale:** The MTUS allows for epidural steroid injections when radiculopathy is documented on physical examination and corroborated by imaging or electrodiagnostic studies in individuals who have not improved with conservative care. Based on the clinical documentation provided, there is insufficient clinical evidence that the proposed procedure meets the MTUS guidelines. Specifically, there is no documentation of radiculopathy corroborated by a diagnostic study. Also the record reflects of previous epidural steroid injection on 2/17/14 with patient having 4 months of pain relief; however there is no documentation of at least a 50% reduction in pain. As such, the requested procedure is deemed not medically necessary.

**Lumbar Traction Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** Lumbar traction/decompression through traction and spinal decompressive devices is not recommended for treatment of acute, subacute, or chronic low back pain or treatment of radicular symptoms. After reviewing the medical records provided there was no identifiable documentation or reasoning to deviate from the guidelines. Therefore, this request is deemed not medically necessary.

**Aquatic Therapy two times a week for six weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute LLC; Corpus Christi TX; www.odg-twc.com Section Low Back Lumbar and Thoracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** Aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. After review of the medical records provided, there were no specific criteria that

would prevent the injured worker from participating in a land-based physical therapy program. Therefore, this request is deemed not medically necessary.