

Case Number:	CM14-0207827		
Date Assigned:	12/19/2014	Date of Injury:	01/18/1999
Decision Date:	02/28/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/11/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Maryland, District of Columbia
 Certification(s)/Specialty: Internal Medicine

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 employer was a 40 year old male who sustained an industrial injury on 01/18/1999. Prior treatment included TENS unit, medications and injections. MRI of lumbar spine from 10/07/14 was reviewed. It revealed solidly incorporated intervertebral hardware at L5-S1, mild bilateral hypertrophic facet joint arthrosis with synovitis more prominent on the right side at L5-S1 level, with mild bilateral neural foraminal narrowing with possible mild impingement of the right L5 exiting nerve root. Diffuse posterior disc bulge most prominent in the right foraminal and extraforaminal at L4-L5 aspect with posterior annular fissure without central canal stenosis with moderate bilateral facet joint arthrosis, moderate right neural foraminal narrowing with mild impingement of the right exiting L4 nerve root and diffuse posterior disc bulge at L3-L4 along with facet and ligamentum flavus hypertrophy causing mild central canal stenosis. The progress note from 11/10/14 was reviewed. Subjective complaints included unchanged low back and leg pain. He had injections in past which helped him temporarily. The medications continued to be helpful in allowing him to stay functional and active. He stayed in bed most days due to pain without medications. His medications included Norco, Lidoderm patch, Soma, Ibuprofen and Cymbalta. He continued to use TENS unit and found it to be helpful. He tried to go back to work and was told that he was unable to continue working as a truck driver due to his medications. He denied neurological symptoms or new symptoms. Pertinent examination findings included decreased range of motion of the lumbar spine, tenderness of SI joints, positive Patrick's sign, tender lower lumbar paraspinals and positive straight leg raising test. The diagnoses included low back pain, lumbar degenerative disc disease, lumbar radiculitis, muscle pain and chronic pain

syndrome. The progress note from October 2014 revealed testicular pain and difficulty with urinary incontinence. He had a prior history of back surgery after which he had a resolution of bladder symptoms until this visit. Given the MRI findings of several disc bulges and some nerve impingement and his new onset bladder symptoms, an EMG/NCV was requested along with physical therapy to reduce some of the symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2xWk x 4-8Wks for the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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 disorders, Physical therapy.

Decision rationale: The employer was a 40 year old male who sustained an industrial injury on 01/18/1999. Prior treatment included TENS unit, medications and injections. MRI of lumbar spine from 10/07/14 was reviewed. It revealed solidly incorporated intervertebral hardware at L5-S1, mild bilateral hypertrophic facet joint arthrosis with synovitis more prominent on the right side at L5-S1 level, with mild bilateral neural foraminal narrowing with possible mild impingement of the right L5 exiting nerve root. Diffuse posterior disc bulge most prominent in the right foraminal and extraforaminal at L4-L5 aspect with posterior annular fissure without central canal stenosis with moderate bilateral facet joint arthrosis, moderate right neural foraminal narrowing with mild impingement of the right exiting L4 nerve root and diffuse posterior disc bulge at L3-L4 along with facet and ligamentum flavus hypertrophy causing mild central canal stenosis. The progress note from 11/10/14 was reviewed. Subjective complaints included unchanged low back and leg pain. He had injections in past which helped him temporarily. The medications continued to be helpful in allowing him to stay functional and active. He stayed in bed most days due to pain without medications. His medications included Norco, Lidoderm patch, Soma, Ibuprofen and Cymbalta. He continued to use TENS unit and found it to be helpful. He tried to go back to work and was told that he was unable to continue working as a truck driver due to his medications. He denied neurological symptoms or new symptoms. Pertinent examination findings included decreased range of motion of the lumbar spine, tenderness of SI joints, positive Patrick's sign, tender lower lumbar paraspinals and positive straight leg raising test. The diagnoses included low back pain, lumbar degenerative disc disease, lumbar radiculitis, muscle pain and chronic pain syndrome. The progress note from October 2014 revealed testicular pain and difficulty with urinary incontinence. He had a prior history of back surgery after which he had a resolution of bladder symptoms until this visit. Given the MRI findings of several disc bulges and some nerve impingement and his new onset bladder symptoms, an EMG/NCV was requested along with physical therapy to reduce some of the symptoms. According to Official Disability Guidelines, for lumbar sprains and strains and intervertebral disc disorders without myelopathy, a total of 10 visits over 8 weeks is recommended. There is documentation of worsening of symptoms, new onset bladder symptoms

and an MRI showing neural foraminal stenosis. There is no documentation of recent physical therapy. Hence a request for physical therapy for lumbar spine seems medically necessary and appropriate.