MAXIMUS Federal Services

Case Number:	CM15-0100871		
Date Assigned:	05/29/2015	Date of Injury:	02/20/2015
Decision Date:	07/09/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	05/20/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 37-year-old male sustained an industrial injury on 2/20/15. He subsequently reported low back pain. Diagnoses include lumbosacral sprain/ strain and lumbosacral neuritis or radiculitis. Treatments to date include x-ray testing, chiropractic care, physical therapy and prescription pain medications. The injured worker continues to experience lumbosacral symptoms. Upon examination, lumbar range of motion is decreased with pain noted upon all planes to the lumbar spine. Milgram's test is positive and Kemp's test is positive bilaterally. Muscle testing revealed 5/5 bilaterally for the L4-S1 dermatome levels. Pinwheel examination revealed a right sided hypoesthesia at the L5-S1 dermatome levels at this time. A request for physical performance test, x-rays of the lumbar spine, pain management referral and additional chiropractic/ physiotherapy treatments for the low back 2x3 was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Performance Test: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness For Duty Chapter, Functional Capacity Evaluation (FCE) Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Functional Capacity Evaluation: ACOEM guidelines, Chapter 7, p137-139.

Decision rationale: According to the 04/10/2015 report, this patient presents with low back pain that radiates to the right buttock, right posterior thigh and right anterior thing. The current request is for Physical Performance Test "to determine work restriction." The Utilization Review denial letter state The ODG recommends the performance of an FCE when there prior unsuccessful RTW attempts; Conflicting medical reporting on precautions and/or fitness for modified jobs; Injuries that requires detailed exploration of worker's abilities. This has not been documented. The patient is not indicated to require physical performance tests. The request for authorization is on 04/14/2015. The patient's work status is to return to work on 04/13/2015 with on modified work. Regarding Functional/Capacity Evaluation, ACOEM Guidelines page 137 states, "The examiner is responsible for determining whether the impairment results in functional limitations. The employer or claim administrator may request functional ability evaluations. These assessments also may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace." In this case, the treater does not explain why FCE is crucial, and it is not requested by the employer or the claims administrator. The FCE does not predict the patient's actual capacity to perform in the workplace. This request is not medically necessary.

X-rays of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, radiography (x-rays).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines low back chapter under Radiography.

Decision rationale: According to the 04/10/2015 report, this patient presents with low back pain that radiates to the right buttock, right posterior thigh and right anterior thing. The current request is for X-rays of the lumbar spine. The request for authorization is on 04/14/2015. The patient's work status is to return to work on 04/13/2015 with on modified work. Regarding radiography of the lumbar spine, ODG states "Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks." ODG further states indication for x-ray is considered when there Lumbar spine trauma; a serious bodily injury, neurological deficit, seat belt (chance) fracture or uncomplicated low back pain; trauma, steroids, osteoporosis, over 70, suspicion of cancer, and infection. Review of the provided reports indicate the patient has constant dull low back pain with no new neurological exam findings. In this case, there is no documentation of Lumbar spine trauma; a serious bodily injury, neurological deficit, seat belt (chance) fracture or uncomplicated low back pain; trauma, steroids, osteoporosis, over 70, suspicion of cancer, and infection to consider an X-ray. The patient does not present any of the concerns addressed in ODG to consider X-rays. This request is not medically necessary.

Pain Management Referral: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Consultations and Examinations Ch: 7 page 127.

Decision rationale: According to the 04/10/2015 report, this patient presents with low back pain that radiates to the right buttock, right posterior thigh and right anterior thing. The current request is for Pain Management Referral. The request for authorization is on 04/14/2015. The patient's work status is to return to work on 04/13/2015 with on modified work. Regarding consultations, ACOEM states that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case, the patient continues to experience constant low back pain with radiating pain to the lower extremities. The current request is supported by the ACOEM guidelines for specialty referral. The treating physician feels that additional expertise including Pain Management may be required. The request is medically necessary.

Additional Chiropractic/Physiotherapy treatments for the Low Back 2x3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: According to the 04/10/2015 report, this patient presents with low back pain that radiates to the right buttock, right posterior thigh and right anterior thing. The current request is for Additional Chiropractic/Physiotherapy treatments for the Low Back 2x3. The Utilization Review denial letter state "the patient has unknown prior sessions of Chiro and should be progressed to an in depended home exercise program (HEP) as there is no evidence of significant functional deficits that would support the need for continued supervised therapy." The request for authorization is on 04/14/2015. The patient's work status is to return to work on 04/13/2015 with on modified work. Regarding chiropractic manipulation, MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. In reviewing of the provided reports, UR allured that the patient has had chiropractic care recently but unknown number of sessions and time frame. There was no documentation of functional improvement. Without this information, one cannot consider additional treatments. While MTUS guidelines allow up to 18 sessions of chiro treatments following initial trial of 3-6. In this case, chiro therapy treatment history is not known. MTUS page 8 requires that the treater provide monitoring of the patient's progress and make appropriate recommendations. Therefore, the requested chiropractic treatments are not medically necessary.