

Case Number:	CM15-0182583		
Date Assigned:	09/23/2015	Date of Injury:	07/22/2004
Decision Date:	10/28/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	09/16/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 injured worker is a 49 year old female, who sustained an industrial-work injury on 7-22-04. She reported initial complaints of lumbar pain. The injured worker was diagnosed as having lumbosacral neuritis, radiculitis. Treatment to date has included medication, and diagnostics. MRI results were reported on 12-27-14 of the lumbar spine noted grade 1 retrolisthesis of L5 over S1, disc protrusion without effacement of the thecal sac, spinal canal and neural foramina are patent at all lumbar levels. Currently, the injured worker complains of ongoing back and right hip pain rated 5 out of 10. Per the primary physician's progress report (PR-2) on 8-24-15, exam noted slow and guarded gait, straight leg raise was positive, decreased lumbar ranges of motion with spasms. Current plan of care includes physical therapy and MRI (magnetic resonance imaging) due to worsening symptoms. The Request for Authorization requested service to include Physical therapy with traction to L/S (8) sessions 2x4 and MRI of the lumbar spine without contrast. The Utilization Review on 9-10-15 denied the request for Physical Therapy due to lack of documentation of specific objective functional deficits requiring supervised therapy verses a home exercise program and MRI (magnetic resonance imaging) of the lumbar spine due to lack of neurological deficits (alterations in strength, reflex, or sensation).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy with traction to L/S (8) sessions 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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 - Lumbar & Thoracic (Acute & Chronic), Powered traction devices.

Decision rationale: The claimant sustained a work injury in July 2004 and continues to be treated for low back pain. An MRI of the lumbar spine was obtained on 12/31/14 with findings of disc degeneration with retrolisthesis at L5/S1. Treatments have included physical therapy with completion of 16 sessions between February and May 2015. When seen, pain was rated at 5/10. Physical examination findings included positive right straight leg raising with limited lumbosacral range of motion. There was a slow and guarded gait. An x-ray showed findings of worsening disc degeneration at L5/S1 with retrolisthesis. She was referred for physical therapy for eight sessions to include traction and for another MRI of the lumbar spine due to worsening spasms. The use of a powered traction device for the lumbar spine is not recommended. While there are some limited promising studies, the evidence in support of powered traction devices in general, and specifically vertebral axial decompression, is insufficient to support its use in low back injuries. Use of these devices may also have risks, including the potential to cause sudden deterioration requiring urgent surgical intervention. The request is not appropriate or medically necessary.

MRI of the lumbar spine without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines.

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-Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

Decision rationale: The claimant sustained a work injury in July 2004 and continues to be treated for low back pain. An MRI of the lumbar spine was obtained on 12/31/14 with findings of disc degeneration with retrolisthesis at L5/S1. When seen, pain was rated at 5/10. Physical examination findings included positive right straight leg raising with limited lumbosacral range of motion. There was a slow and guarded gait. An x-ray showed findings of worsening disc degeneration at L5/S1 with retrolisthesis. She was referred for physical therapy for eight sessions to include traction and for another MRI of the lumbar spine due to worsening spasms. Guidelines indicate that a repeat MRI of the lumbar spine is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). In this case, there is no apparent significant change in symptoms or findings suggestive of significant new pathology. There are no reported neurological deficits. The requested MRI is not considered medically necessary.

