

Case Number:	CM15-0086121		
Date Assigned:	05/08/2015	Date of Injury:	03/25/2014
Decision Date:	06/10/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	05/05/2015

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: New York

Certification(s)/Specialty: Neurological Surgery

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 25 year old male patient who sustained an industrial injury on 03/25/2014. The patient described having been squatting down and lifting up a battery when it began to slip from his arms. He tensed up and tried to catch the battery, at which time he felt something pop in his lower back; followed by a sharp, shooting pain. He has acute onset of groin, and lumbar back pains. A primary treating office visit dated 03/20/2015 reported the patient with subjective complaint of constant severe low back pain. The pain radiates to the left lower extremity with associated numbness, tingling, and weakness. In addition, he reports the pain radiating into buttocks. He did undergo a volume lumbar epidural steroid injection at L5-S-1 on 03/03/2015 with noted temporary improvement of symptoms by 60-70 % for a total of six days. His low back pain has since worsened and returned to the previous intensity of pain. Currently he is using Soma, Ultracet, and Voltaren XR for pain management. Physical examination showed the lumbar spine with limited range of motion with forward flexion at 45/60 degrees. There is mild muscle spasm noted over the lumbar paravertebral musculature. Testing revealed straight leg raise, Braggard's and Bowstring's are positive on the left. There is weakness over the left gastrocnemius and peroneus longus motor groups at 4/5. Sensory deficit is noted over the left S1 dermatome. The left Achilles deep tendon reflex is absent. He is diagnosed with: L5-S1 disc protrusion with left S1 radiculopathy, and L4-5 herniated nucleus pulposus. The plan of care involved: recommendation to undergo a left-sided L5-S1 interlaminar laminotomy with microdiscectomy. He is currently temporary totally disabled. On 11/21/2014 a

doctor's first illness report showed subjective complaint of groin and low back pain. The following diagnoses were applied: left-sided lumbar curvature; scoliosis; retrolisthesis at L4-5; rule out stenosis at L5-S1 with radiculitis and radiculopathy to the left. He was physically evaluated, and underwent radiographic imaging. He is prescribed medications, and to undergo a magnetic resonance imaging study, and computerized tomography scan; along with follow up visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative Physical Therapy with a total Of 24 Visits: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Chapter-Post operative-lumbar discectomy/laminectomy.

Decision rationale: The ODG guidelines do not recommend a total of 24 visits of Post operative physical Therapy. The ODG guidelines do recommend a program that follows a tapering principle as well as compliance with a home exercise program. The requested Treatment: Post operative Physical Therapy with a total Of 24 Visits is NOT Medically necessary and appropriate.

Associates Surgical Services: Off the Shelf Lumbar Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Lumbar support.

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 Chapter-back brace, post operative.

Decision rationale: The ODG guidelines note that use of a postoperative back brace is under study. They note that a standard brace would be preferred over a custom post-op brace. They note there may be special circumstances in which external immobilization might be desirable. Documentation does not indicate these special circumstances. The requested treatment: Associates Surgical Services: Off the Shelf Lumbar Brace is NOT Medically necessary and appropriate.

Associates Surgical Services: Transportation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg, Transportation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83.

Decision rationale: The California MTUS Guidelines note the patient's role to achieve functional recovery means the patient must assume certain responsibilities. Namely the patient must adhere to exercise and medication regimens. The patient must keep appointments. Documentation does not contain evidence of transportation problems. The requested treatment: Associated Surgical Services: Transportation is NOT Medically necessary and appropriate.

Associates Surgical Services: Soma 350 mg by mouth twice a day as needed for muscle spasm Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Soma.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics-carisoprodol Page(s): 65.

Decision rationale: The California MTUS guidelines note that carisoprodol is metabolized to meprobamate, an axiolytic that is a schedule IV controlled substance. Side effects include drowsiness, psychological and physical dependence and withdrawal with acute discontinuation. It is not recommended for longer than a 2 to 3 week period. The requested treatment: Associated Surgical Services: Soma 350 mg by mouth twice a day as needed for muscle spasm Qty 60 is NOT Medically necessary and appropriate.

Associates Surgical Services: Continue Physical Therapy for the Lumbar Spine 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Chapter-lumbar discectomy/laminectomy.

Decision rationale: The ODG guidelines do not recommend Associated Surgical Services: Continue Physical Therapy for the Lumbar Spine 2 times a week for 4 weeks. The ODG guidelines do recommend a program that follows a tapering principle as well as compliance with a home exercise program. The requested Treatment: Post operative Physical Therapy for the Lumbar Spine 2 times a week for 4 weeks is NOT Medically necessary and appropriate.