

<b>Case Number:</b>	CM14-0023314		
<b>Date Assigned:</b>	05/12/2014	<b>Date of Injury:</b>	03/04/2012
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	01/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2014

### 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, has a subspecialty in Pain Medicine and Spinal Cord Medicine and is licensed to practice in Massachusetts. 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 claimant has a history of a slip and fall work injury while working as a baker/server on 03/04/12 and is being treated for a lumbar spine strain. On the date of injury she continued to work and sought medical care approximately one week later. She was placed out of work and participated in 12 sessions of physical therapy with temporary relief. She underwent an MRI of the lumbar spine and epidural injections. Epidural injections provided 4-6 weeks of pain relief. She was evaluated for surgery. An MRI of the lumbar spine in May 2013 showed findings of disc bulging. EMG/NCS testing showed findings of an acute left L5 radiculopathy. She was seen by the requesting provider on 12/03/13. She was referred for pain management for facet injections and for physical therapy. She was seen for a pain management evaluation on 01/22/14 with low back pain radiating into the left greater than right lower extremity. Pain was rated at 8/10. She was having neck pain and headaches. Medications were Ultram, Fexmid, Restoril, and Zoloft. Physical examination findings included appearing in moderate distress. She was noted to move slowly and had difficulty transitioning from seated to standing. She had posterior cervical paraspinal muscle tenderness with trigger points and decreased range of motion. There was bilateral lumbar paraspinal muscle tenderness with trigger points and decreased range of motion. She had decreased lower extremity sensation and positive straight leg raising bilaterally. Recommendations included authorization for epidural injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CONTINUED PHYSICAL THERAPY:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant is more than 2 years status post work-related injury and continues to be treated for chronic low back pain with bilateral lower extremity radicular symptoms. Treatments have included participation in a course of physical therapy. In terms of physical therapy, patients are expected to continue active therapies at home. Compliance with a home exercise program would be expected and would not require continued skilled physical therapy oversight. A home exercise program could be performed as often as needed/appropriate rather than during scheduled therapy visits and could include use of TheraBands and self-applied modalities. The claimant has no other identified impairment that would preclude her from performing such a program. Providing additional skilled physical therapy services again does not reflect a fading of treatment frequency and would promote dependence on therapy-provided treatments. Therefore, the request is not medically necessary.

**PAIN MANAGEMENT REFERRAL FOR FACET INJECTION:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Occupational Medicine Practice Guidelines Independent Medical Examinations and Consultations.

**Decision rationale:** The claimant is more than 2 years status post work-related injury and continues to be treated for chronic low back pain with bilateral lower extremity radicular symptoms. Although she has imaging with an MRI of the lumbar spine-showing disc bulging without reported neural compromise, EMG/NCS testing showed findings of an acute left L5 radiculopathy. Guidelines recommend consideration of a consultation if clarification of the situation is necessary. In this case, the claimant's test results show inconsistent findings and therefore the requested consultation was medically necessary.

**WORK CONDITIONING:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning Page(s): 125.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125.

**Decision rationale:** The claimant is more than 2 years status post work-related injury and continues to be treated for chronic low back pain with bilateral lower extremity radicular symptoms. Treatments have included participation in a course of physical therapy. The claimant has ongoing symptoms and has been referred for physical therapy. Criteria for a Work Conditioning Program include completion of an adequate trial of physical or occupational therapy with improvement followed by plateau, defined return to work goal, and the worker must be no more than 2 years past date of injury. In this case, the claimant is more than two years status post injury. The requested provider referred her for additional therapy indicating that he considered her treatment incomplete. There is no identified return to work plan. Therefore, the request is not medically necessary.