

<b>Case Number:</b>	CM15-0175499		
<b>Date Assigned:</b>	09/16/2015	<b>Date of Injury:</b>	03/24/2010
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/07/2015

### 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: Pennsylvania, Ohio, 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:

The injured worker (IW) is a 67 year old female who sustained an industrial injury on 03-24-2010. The injured worker was diagnosed as having lumbago, displacement of lumbar intervertebral disc without myelopathy, sacroiliitis not elsewhere classified, and spinal stenosis of lumbar region. Treatment to date has included non-steroidal anti-inflammatories, and physical therapy with traction and stretching exercises at home. In the provider notes of 06-15-2015 the injured worker complains of aching and cramping pain in the central low back that radiates across the low back with spasms. She rates the pain as a 5 on a scale of 0-10. He has no complaints of urinary or bowel problems. The worker is able to perform normal activities of daily living such as self-care. Vacuuming and mopping exacerbates her low back pain. On exam, the worker has an antalgic gait and a forward flexed posture. Range of motion of the lumbar spine is restricted secondary to pain. Straight leg raising test is negative. There is bilateral paraspinal tenderness to palpation. The lower extremity range of motion is normal, and there is no joint instability. The IW is not working. The treatment plan of care is medication management, a MRI of the lumbar spine, follow ups as scheduled, massage therapy, and physical therapy with traction. A request for authorization was submitted for a MRI lumbar spine with contrast, Physical therapy with traction and massage, and Ibuprofen 800mg three times a day. A utilization review decision 08-19-2015 non-certified the request for a MRI of the lumbar spine, Non-certified the request for Physical therapy with traction and massage, and modified the Ibuprofen request to certify Ibuprofen 800mg #90.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI lumbar spine with contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI's.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Summary.

**Decision rationale:** MTUS/ACOEM recommends MRI L SPINE if there are specific red flag findings on history and musculoskeletal and neurological examination. The records do not document such red flag findings at this time. The rationale/indication for the requested lumbar MRI are not apparent. Moreover the records do not document a change in neurological examination to support a need for a repeat MRI as in this case. This request is not medically necessary.

**Physical therapy with traction and massage:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy, Physical Medicine.

**Decision rationale:** MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. Therefore this request is not medically necessary. Additionally MTUS recommends massage for limited indications up to 6 visits in the acute phase of an injury. This treatment is intended as an adjunct to active treatment and to facilitate early functional restoration. Massage is a passive treatment which is not recommended for ongoing or chronic use. The request in this case is not consistent with these guidelines; for this additional reason, the request is not medically necessary.

**Ibuprofen 800mg three times a day:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications.

**Decision rationale:** MTUS recommends NSAIDs as a first-line drug class for chronic musculoskeletal pain. A prior physician review concluded that this medication is not medically necessary due to the lack of objective documentation of functional benefit. However MTUS does not require objective functional improvement to support benefit from NSAIDs; reported subjective improvement as in this case also is consistent with MTUS guidelines. This request is medically necessary.