

<b>Case Number:</b>	CM15-0075431		
<b>Date Assigned:</b>	04/27/2015	<b>Date of Injury:</b>	12/04/2012
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

### 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 54 year old female who sustained a work related injury December 4, 2012. Past history included ALIF (anterior lumbar interbody fusion) with posterior instrumentation L5-S1, February, 2015. According to a physician's progress report, dated March 12, 2015, the injured worker presented for follow-up after surgery, doing well but is having cramping in the right leg. She is currently in a pain management program. She is able to toe walk and heel walk, has 1+ reflex in the knees and ankles, and palpable pulses. Diagnoses included chronic low back pain; adjacent segment disease at L2-3, L3-4, and L4-5. Treatment plan included request for authorization for a lumbar CT scan, ultrasound to rule out deep vein thrombosis, 8 sessions of pool therapy and physical therapy x 12 for the low back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultrasound to rule out DVT, quantity 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Comp, 2012 on the web, [www.odgtreatment.com](http://www.odgtreatment.com), Intergrated Treatment/Disability Duration Guidelines, Ultrasound.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Ultrasound (diagnostic), Venous Thrombosis.

**Decision rationale:** Regarding the request for ultrasound to rule out DVT, California MTUS does not address the issue. ODG recommends the use of diagnostic ultrasound for venous thrombosis when there is suspicion of deep vein thrombosis. Within the documentation available for review, there are no symptoms/findings suggestive of deep vein thrombosis other than pain in the calf. In the absence of additional documentation, the currently requested ultrasound to rule out DVT is not medically necessary.

**Lumbar CT Scan, quantity 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints page(s): 182.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, CT (computed tomography).

**Decision rationale:** Regarding the request for CT scan of the lumbar spine, CA MTUS states CT is recommended for patients with acute or subacute radicular pain syndrome that have failed to improve within 4 to 6 weeks and there is consideration for an epidural glucocorticoid injection or surgical discectomy. Official Disability Guidelines state CT is indicated for thoracic or lumbar spine trauma, myelopathy to evaluate pars defect not identified on plain x-rays, and to evaluate successful fusion if plain x-rays do not confirm fusion. Within the documentation available for review, there are no physical examination findings consistent with radicular pain syndrome that has failed to improve. There is a recent fusion but no plain x-rays that do not confirm fusion. In the absence of such documentation, the currently requested computed tomography (CT) scan of the lumbar spine is not medically necessary.

**Aquatic Therapy for the Low Back, quantity 8: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints page(s): 298, Chronic Pain Treatment Guidelines 9792.20 - 9792.26 page(s): 22, 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for aquatic therapy, Chronic Pain Treatment Guidelines state that aquatic therapy is recommended as an optional form of exercise therapy where available as an alternative to land-based physical therapy. They go on to state that it is specifically recommended whenever reduced weight bearing is desirable, for example extreme obesity. Guidelines go on to state that for the recommendation on the number of supervised

visits, see physical therapy guidelines. Within the documentation available for review, there is no documentation indicating why the patient would require therapy in a reduced weight-bearing environment. Furthermore, there is no indication as to how many physical/aquatic therapy sessions the patient has undergone and what specific objective functional improvement has been obtained with the therapy sessions already provided. Finally, there is no statement indicating whether the patient is performing a home exercise program on a regular basis, and whether or not that home exercise program has been modified if it has been determined to be ineffective. In the absence of clarity regarding those issues, the currently requested aquatic therapy is not medically necessary.

**Physical Therapy for the Low Back (land), quantity 12: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints page(s): 298, Chronic Pain Treatment Guidelines 9792.20 - 9792.26 page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS for trial, fortunately, the last reviewer modified the current request. In the absence of such documentation, the current request for physical therapy is not medically necessary.