

<b>Case Number:</b>	CM15-0075866		
<b>Date Assigned:</b>	04/27/2015	<b>Date of Injury:</b>	07/15/2014
<b>Decision Date:</b>	05/27/2015	<b>UR Denial Date:</b>	04/08/2015
<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  
Certification(s)/Specialty: Emergency 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 53-year-old male, with a reported date of injury of 07/15/2014. The diagnoses include lumbosacral sprain/strain, spondylolisthesis at L4-5, left lower extremity radiculopathy, rule out lumbar disc protrusion/lumbar stenosis, idiopathic peripheral autonomic neuropathy, and unspecified disorder of autonomic nervous system. Treatments to date have included an MRI of the lumbar spine, acupuncture, a home exercise program, and oral medications. Patient has reportedly completed up to 6 prior physical therapy session. Urine Drug Screen dated 11/19/14, 2/4/15, 3/4/15 was negative. The progress report dated 01/14/2015 indicates that the injured worker complained of constant low back pain, with radiation to the left lower extremity with numbness and tingling. He rated the pain 9 out of 10. The objective findings include lumbar flexion at 35 degrees, lumbar extension at 5 degrees, right lumbar lateral flexion at 10 degrees, left lumbar lateral flexion at 10 degrees, tenderness to palpation along the lumbar spine, and positive bilateral straight leg raise test. The treating physician requested a follow-up visit in 4-6 weeks, Norco 10/325mg #90, and physical therapy for the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Follow-up visits in 4-6 weeks:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** As per MTUS ACOEM guidelines, providers can continue to monitor, assess and provide treatment. Patient is still undergoing active management and has continued pain that is being worked up and managed. The patient was just switched from tramadol to Norco. Reassessment is medically necessary. Follow-up visit is medically necessary.

**Norco 10/325 mg, ninety count:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 - 81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

**Decision rationale:** As per MTUS Chronic pain guidelines, As per MTUS chronic pain guidelines, initiation of opioids require establishment of a treatment plan, current pain/pain relief assessment and failure of non-opioid treatment. Patient has had chronic treatment with tramadol and other medications with no benefit in pain control. Patient was switched to Norco due to failure of tramadol. Pt has appropriate monitoring for abuse and has a pain contract documented. A trial of Norco therapy is medically necessary.

**Physical therapy for the lumbar spine, twice weekly for four weeks:** Upheld

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

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

**Decision rationale:** As per MTUS Chronic pain guidelines physical therapy is recommended for many situations with evidence showing improvement in function and pain. Patient also has had an unknown number of physical therapy sessions in the past although at least 6 prior sessions were documented with no documentation of any benefit. The provider has failed to provide any rationale or reasoning for additional sessions. There is no documentation as to why the patient cannot perform home exercise program or why additional sessions are necessary. Additional Physical Therapy is not medically necessary.