MAXIMUS Federal Services

Case Number:	CM15-0078378		
Date Assigned:	04/30/2015	Date of Injury:	09/24/2014
Decision Date:	06/04/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	04/23/2015

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: Texas, Florida, California
Certification(s)/Specialty: Preventive Medicine, Occupational 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 61 year old male who sustained an industrial injury on 09/24/2014. Diagnoses include lumbar disc herniation without myelopathy, lumbago, lumbar myalgia, lumbar myospasm and left sided lumbar neuritis and radiculitis. Treatment to date has included diagnostic studies, lumbar support, medications, aqua therapy, home exercise program, and physical therapy. A physician progress note dated 02/06/2015 documents the injured worker complains of constant low back pain that is dull, sharp, achy, throbbing, numbing, tingling and shooting in character with spasms. On a scale of 0-10 he rates his pain as 9 while resting and with activity. The pain is associated with numbness, and the pain radiates into the abdomen, right shoulder, left leg, left knee, left foot and left ankle. On examination of the lumbar spine there was tenderness, guarding and spasm over the paravertebral and gluteal regions bilaterally. Seated straight leg raise test was positive bilaterally. Range of motion was restricted due to pain and spasm. Magnetic Resonance Imaging of the lumbar spine done on 10/07/2014 revealed L5- S1 3mm left central disc herniation minimally flattens the neighboring left S1 dural nerve root sleeve with the left lateral recess causing mild left lateral recess stenosis. There is posterior discal T2 high signal intensity zone/annular tear. L4-L5-4mm central disc-protrusion along with bilateral facet hypertrophy associated with mild left neural foraminal stenosis. L3/L4-2mm disc bulge and L2-L3-3mm disc bulge. Treatment requested is for X-ray of lumbar spine including AP, lateral, and flexion/extension views, and Physical therapy 3 times a week for 4 weeks to evaluate & treat lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times a week for 4 weeks to evaluate & treat lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 of 127.

Decision rationale: The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request for more skilled, monitored therapy was appropriately non-certified and is not medically necessary.

X-ray of lumbar spine including ap, lateral, and flexion/extension views: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) plain lumbar x-rays, and flexion-extension view.

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG notes regarding lumbar plain x-rays: Not recommend routine x-rays in the absence of red flags. (See indications list below.) Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. Regarding flexion-extension

views, the ODG notes under low back: Not recommended as a primary criteria for range of motion. An inclinometer is the preferred device for obtaining accurate, reproducible measurements. See Range of motion (ROM); Flexibility. For spinal instability, may be a criteria prior to fusion, for example in evaluating symptomatic spondylolisthesis when there is consideration for surgery. See Fusion (spinal). Criteria for these studies are not evidence in the records, and the x-rays are not supported and the request is not medically necessary.