

<b>Case Number:</b>	CM14-0205197		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	10/15/2012
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	11/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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. 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 & Rehabn

### 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 underlying date of injury in this case is 10/15/2012. The date of the utilization review under appeal is 11/17/ 2014. The patient was seen in treating physician followup on 10/03/2014 regarding a chronic thoracic strain, lumbosacral strain, degenerative disc disease, and intermittent left leg numbness. No specific neurological deficits were noted on examination. Current treatment requests include an open MRI of the lumbar spine as well as an Interspec IF II device with supplies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Open MRI Lumbar Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter- MRI

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** The ACOEM guidelines, Chapter 12, Low Back, page 309, recommends MRI imaging of the lumbar spine when a specific neurological deficit or red flags for spinal pathology exist. The records do not provide such a rationale for a lumbar MRI. This request is not supported by the treatment guidelines. This request is not medically necessary.

**Interspec IF II with supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 120.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on interferential stimulation does not recommend this as a first-line treatment. The guidelines recommend this as a second-line treatment in specific clinical situations where pain is ineffectively controlled due to side effects or substance abuse or diminished effectiveness of medications. The records are limited and do not provide a rationale as to why this equipment has been requested. This request is not medically necessary.