

<b>Case Number:</b>	CM14-0205858		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	01/04/2014
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	11/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2014

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant is a 62- year old female who sustained an industrial injury. The mechanism of injury occurred when she slipped on a cardboard box while at work injuring her lower back. Her diagnosis is low back pain. She continues to complain of low back pain. On physical exam lumbar flexion is 40 degrees, extension 10 degrees, and rotation 15 degrees. Sensation and reflexes are intact. Strength is 5/5/ in the bilateral lower extremities. Treatment has consisted of medical therapy and physical therapy. The treating provider has requested an MRI of the lumbar spine, TENS unit, and Chiropractic therapy x 8 visits to the low back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 304.

**Decision rationale:** The claimant has a history of chronic low back pain. There is no documentation of any new significant change in the claimant's complaints or exam. He is maintained on medical therapy and there have been no new neurologic findings or subjective

complaints of increased back pain, radiculopathy, and bowel or bladder incontinence. There is no reported consideration for any interventional procedures for the treatment of his chronic back condition. There is no specific indication for the requested MRI of the lumbar spine. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**Transcutaneous Electrical Nerve Stimulation (TENS) for 30 day trial:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

**Decision rationale:** The requested TENS is not medically necessary . Per California MTUS Guidelines it is not recommended as an isolated therapeutic intervention and is only recommended on a one-month trial if it is part of a comprehensive rehabilitation program. There is no documentation indicating that the claimant is part of such a rehabilitation program. There is no report of functional benefit from electrical stimulation under the supervision of a licensed physical therapist. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.

**Chiropractic therapy x8 visits for the low back:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Treatment.

**Decision rationale:** Per the reviewed guidelines, chiropractic treatment is recommended for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. For the treatment of low back pain the recommendation is a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total up to 18 visits over 6-8 weeks. The requested visits exceed the recommendations of the guidelines. Medical necessity for the requested item has not been established. The requested item is not medical necessary.