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| <b>Case Number:</b>   | CM15-0009371 |                              |            |
| <b>Date Assigned:</b> | 01/27/2015   | <b>Date of Injury:</b>       | 10/01/2014 |
| <b>Decision Date:</b> | 04/21/2015   | <b>UR Denial Date:</b>       | 12/17/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/15/2015 |

### 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: New York  
 Certification(s)/Specialty: Internal 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:

This 26 year old male was injured 10/1/14 in an industrial accident involving lifting where he experienced a pop in his lower back. He is currently experiencing constant sharp pain in the mid to lower back with pain intensity of 8-9/10. He is taking Anaprox and Tramadol. He was treated with ice and moist heat and lumbar sacral back support. He was diagnosed with thoracic spine pain, thoracic and lumbar sprain/strain, lumbar radiculopathy, lumbago and rule out lumbar disc protrusion. Diagnostics include radiographs of the lumbar and thoracic spine. The treating physician requested MRI of the lumbar spine, electromyography/nerve conduction velocity studies of bilateral lower extremities, physical therapy 2X4 and transcutaneous electrical nerve stimulator to help manage pain, increase range of motion and increase activities of daily living. On 12/17/14 Utilization Review non-certified the requests for Physical Therapy 2X4 Lumbar Spine citing ODG-TWC; Electromyography/Nerve Conduction Velocity Lower Extremities citing ODG-TWC; Back Brace citing MTUS/ACOEM and Home Transcutaneous Electrical Nerve Stimulator citing MTUS/ACOEM and ODG-TWC.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 X 4, 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 (ODG) - ODG-TWC.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Chapter.

**Decision rationale:** MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Lumbar sprains and strains and intervertebral disc disorders without myelopathy. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Documentation indicates that the injured worker had already been prescribed 6 sessions of Physical Therapy with only minimal improvement in strength and mobility. Given that the injured worker has not had significant improvement in physical function with an initial course of physical therapy, medical necessity for additional physical therapy has not been established. Per guidelines, the request for Physical Therapy 2 X 4, Lumbar Spine is not medically necessary.

**EMG/NCV:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Consideration, page 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Nerve conduction studies (NCS).

**Decision rationale:** Per guidelines, Electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks, and to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy. MTUS and ODG guidelines state that nerve conduction studies or Electromyography are not necessary when a patient is already presumed to have symptoms on the basis of radiculopathy or if radiculopathy is clinically obvious. The injured worker complaints of radicular low back pain and documentation reveals objective clinical findings of radiculopathy on physical exam. With guidelines not being met, the request for EMG/NCV is not medically necessary.

**Back Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Initial Care, pg 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar supports.

**Decision rationale:** MTUS states that the use of Lumbar supports to treat low back pain has not been shown to have any lasting benefit beyond the acute phase of symptom relief. Per guidelines, lumbar supports may be recommended as an option for compression fractures and specific treatment of spondylolisthesis and documented instability. Long term use of lumbar supports is not recommended. Chart documentation fails to show significant improvement with the initial use of a back brace by this injured worker. The request for a Back Brace is not medically necessary per guidelines.

**Home Tens Unit of Bilateral Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114.

**Decision rationale:** MTUS guidelines state that a TENS unit may be recommended in the treatment of chronic intractable pain conditions, if there is documentation of pain for at least three months duration, evidence that other appropriate pain modalities including medications have been tried and failed and that a one-month trial period of the TENS unit has been prescribed, as an adjunct to ongoing treatment modalities within a functional restoration program. Documentation provided does not show that a previous trial period of TENS unit has been prescribed, making the request for a home TENS unit not indicated. The request for Home Tens Unit of Bilateral Lower Extremities is not medically necessary.