

<b>Case Number:</b>	CM15-0132874		
<b>Date Assigned:</b>	07/21/2015	<b>Date of Injury:</b>	05/08/2013
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	06/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2015

### 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:

This 51-year-old man sustained an industrial injury on 5/8/2013. The mechanism of injury is not detailed. Evaluations include electromyogram/nerve conduction studies of the bilateral lower extremities dated 3/26/2015. Diagnoses include lumbar spine sprain/strain and bilateral wrist sprain/strain. Treatment has included oral medications and physical therapy. Physician notes dated 5/19/2015 show complaints of low back pain rated 4/10. Recommendations include continue physical therapy, lumbosacral brace, interferential unit for home use, modified work restrictions, and follow up in six weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2x6, 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 Physical Medicine, Page 98-99 Page(s): 98-99.

**Decision rationale:** The requested Physical therapy 2x6, lumbar spine, is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, Page 98-99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has low back pain rated 4/10. The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, or the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical therapy 2x6, lumbar spine is not medically necessary.

**DME: IF unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ICS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation, Page(s): 118-120.

**Decision rationale:** The requested DME: IF unit is not medically necessary. CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment is "not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone... There are no published randomized trials comparing TENS to Interferential current stimulation;" and the criteria for its use are: "Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." The injured worker has low back pain rated 4/10. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met, DME: IF unit is not medically necessary.

**DME: LSO brace:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic(Acute & Chronic), Lumbar Supports.

**Decision rationale:** The requested DME: LSO brace is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, Page 301, note, "Lumbar supports have not been shown to have any

lasting benefit beyond the acute phase of symptom relief." Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar Supports, also note "Lumbar supports: Not recommended for prevention. Under study for treatment of nonspecific LBP. Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment." The injured worker has low back pain rated 4/10. The treating physician has not documented the presence of spondylolisthesis, documented instability, or acute post-operative treatment. The criteria noted above not having been met, DME: LSO brace is not medically necessary.