

<b>Case Number:</b>	CM15-0196042		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	08/10/2015
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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: Arizona, California

Certification(s)/Specialty: Family Practice

### 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 45 year old male who sustained an industrial injury on 08-10-2015. According to a progress report dated 09-09-2015, the injured worker's condition had worsened. Pain in the lower back had increased. He was currently on modified duty. He was not tolerating current medication and ran out 3 days ago. Durable medical equipment was helping with symptoms. Light duty was not being accommodated. Pain was increased and he had not taken medications in 3 days. Associated symptoms included parasthesias, radiation of back pain to the right lower extremity, limited back motion and numbness and tingling of the lower extremities, right lower extremity. There were spasms of the thoracolumbar spine and paravertebral musculature. There was tenderness of the thoracolumbar spine and paravertebral musculature. Range of motion of the back was restricted. Sensation was decreased to light touch and pinprick in the right lateral leg, medial foot and dorsal foot. Straight leg raise was positive on the left at 50 degrees and right 30 degrees. Diagnoses included sprain strain lumbar, lumbar radiculopathy and sciatica, sprain lumbosacral. The treatment plan included Acetaminophen, Nabumetone and Orphenadrine Citrate ER. MRI was scheduled for 09-17-2015. An intramuscular Toradol injection was given. Work status included work restrictions. The provider noted that the injured worker must wear a back support. An MRI of the lumbar spine performed on 09-17-2015 showed degenerative change L5-S1 disc with a 2 millimeter broad based posterior disc bulge which abuts both exiting L5 nerve roots. Increased signal in the left facet joint was consistent with left facet arthropathy. On 09-25-2015, Utilization Review non-certified the request for LSO back brace and interferential unit and authorized the request for a heating pad.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**LSO back brace:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, Physical Methods.

**Decision rationale:** According to the ACOEM guidelines, lumbar supports have not been shown to provide lasting benefit beyond the acute phase of symptom relief. In this case, the claimant's injury was over a month prior. Length of use was not specified. The use of a LSO brace is not medically necessary.

**Interferential unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** According to the guidelines an IF unit 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. In this case, the claimant had modified work and had undergone therapy. However, length of use was no specified. The details on use, frequency location, etc was not noted. The IF unit is not a medical necessity.