

<b>Case Number:</b>	CM15-0220158		
<b>Date Assigned:</b>	11/13/2015	<b>Date of Injury:</b>	03/08/1996
<b>Decision Date:</b>	12/28/2015	<b>UR Denial Date:</b>	10/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2015

### 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:

The injured worker is a 59-year-old male who sustained an industrial injury on 03-08-1996. According to an initial comprehensive orthopedic surgery evaluation report dated 09-25-2015, the injured worker reported constant pain in his head that travelled down to his neck into both shoulders and both arms into the fingertips. He reported swelling in the right side of the neck and right shoulder. He reported constant pain in his bilateral right greater than left lower back that was described as deep aching pain, throbbing, pins and needles and burning sensation. He reported left leg and left ankle pain and numbness in the toes. Other symptoms included difficulty falling asleep, anxiety, depression, weight gain, fluctuating weight patten, decreased muscle mass and strength with numbness. Current medications included Ultram ER. MRI of the lumbar spine performed on 05-28-2015 demonstrated degenerative disc disease with a Grade I spondylolisthesis of L5 in relation to S1. This plus atrophy of the facet joints has resulted in moderate central stenosis and moderate encroachment upon the mouth of the right and left neural foramen. The remaining lumbar discs appear normal. Visualization of the upper lumbar was severely visually limited due to a magnetic artifact from prior surgery. Prominent anterior osteophyte formation involving the lumbar spine with modic changes at the L2-3 and L3-4 levels was noted. Diagnoses included lumbar spine disc herniation, cervical spine degenerative disc disease, thoracic spine degenerative disc disease, left ankle-feet sprain and depression. The provider noted that the injured worker had reached permanent and stationary status. Recommendations included urine drug testing, interferential unit, physical therapy to address the head, cervical spine, lumbar spine and bilateral shoulders, Naproxen and a lumbar LSO for

prophylactic purposes to avoid exacerbation of the current injury. An authorization request dated 09-25-2015 was submitted for review. The requested services included baseline urinalysis, Naproxen, encourage exercise, lumbar support and multi-stimulation. On 10-30-2015, Utilization Review non-certified the request for 1 lumbar support-multi-stimulation unit. The request for 1 urinalysis and Naproxen was authorized.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **1 Lumbar support-Multi-stimulation unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Work-Relatedness, Physical Methods, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Lumbar supports.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

**Decision rationale:** The requested 1 Lumbar support-Multi-stimulation 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 constant pain in his head that travelled down to his neck into both shoulders and both arms into the fingertips. He reported swelling in the right side of the neck and right shoulder. He reported constant pain in his bilateral right greater than left lower back that was described as deep aching pain, throbbing, pins and needles and burning sensation. He reported left leg and left ankle pain and numbness in the toes. 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, 1 Lumbar support-Multi-stimulation unit is not medically necessary.