

<b>Case Number:</b>	CM15-0089127		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	10/01/2012
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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: Texas, Illinois  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 63 year old female who sustained an industrial injury on 10/01/2012. There was no mechanism of injury documented. The injured worker was diagnosed with cervical intervertebral disc disorder with myelopathy, lumbar intervertebral disc disorder with myelopathy, peri-arthritis of the shoulder and internal derangement of the knee. The injured worker is status post repair of fracture of radial neck (no date documented). Treatment to date includes cervical, left shoulder and left wrist magnetic resonance imaging (MRI) performed in March 2015, surgery, physical therapy and medications. According to the primary treating physician's progress report on April 3, 2015, the injured worker continues to experience multiple areas of pain rated as an 8/10 currently, 9/10 at its worst and 5/10 at its best. The injured worker reports numbness and tingling of the left hand/wrist. Cervical and lumbar range of motion, left shoulder range of motion and left wrist range of motion were noted to be decreased. According to a prior office visit on March 5, 2015, a positive cervical compression test and Spurling's on the left was noted. The left shoulder was positive for impingement and straight leg raise was positive at 50 degrees. A positive Braggard's, positive Kemp's and a positive sitting root on the right were also documented. Current medications are listed as Naproxen and topical analgesics. Treatment plan consists of follow-up evaluation and the current request for X-rays of the lumbar spine with anterior/posterior lateral, flexion and extension views and Interferential Stimulation (Interspec IFII) rental trial for 60 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-Ray to lumbar spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 303.

**Decision rationale:** The injured worker sustained a work related injury on 10/01/2012. The medical records provided indicate the diagnosis of cervical intervertebral disc disorder with myelopathy, lumbar intervertebral disc disorder with myelopathy, peri-arthritis of the shoulder and internal derangement of the knee. Treatment to date includes cervical, surgery, physical therapy and medications. The medical records provided for review do not indicate a medical necessity for X-Ray to lumbar spine. The medical records indicate the injured worker has mild limitation of lumbar range of motion, positive straight leg raise and paraspinal tenderness, but there was no documentation of progressive neurological dysfunction. The medical record did not include a documentation of the mechanism of the injury. The MTUS does not recommend lumbar spine x rays in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. The request is not medically necessary.

**Interferential stimulator home unit 60 day trial-rental:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

**Decision rationale:** The injured worker sustained a work related injury on 10/01/2012. The medical records provided indicate the diagnosis of cervical intervertebral disc disorder with myelopathy, lumbar intervertebral disc disorder with myelopathy, peri-arthritis of the shoulder and internal derangement of the knee. Treatment to date includes cervical, surgery, physical therapy and medications. The medical records provided for review do not indicate a medical necessity for Interferential stimulator home unit 60 day trial-rental. The MTUS does not recommend Interferential Current Stimulation (ICS) except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. When the above conditions are met, the MTUS recommends a one- month trial. The medical records indicate the injured worker was recommended for physical therapy, but there was no documentation of treatment outcome, if indeed the therapy was rendered. There was no documentation of outcome of treatment; the records indicate the injured worker placed on temporary total disability, rather than being returned to work. The request is not medically necessary.

