

<b>Case Number:</b>	CM15-0116828		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	01/16/2007
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	06/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2015

### 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:

This 63 year old man sustained an industrial injury on 1/16/2007. The mechanism of injury is not detailed. Diagnoses include status post lumbar spine surgery, early lumbar spine adjacent segment degeneration, slight lumbar impingement, depression, and insomnia due to pain. Treatment has included oral medications, physical therapy, and surgical intervention. Physician notes dated 6/8/2015 show complaints of worsening back pain with left leg pain. Recommendations include physical therapy, aquatic therapy, interferential unit, and follow up in four months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, twice weekly for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** According to the MTUS guidelines, therapy is recommended in a fading frequency. They allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self directed home Physical Medicine. The following diagnoses have their associated recommendation for number of visits. Myalgia and myositis, unspecified 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) 24 visits over 16 weeks. According to the ACOEM guidelines: Physical and Therapeutic Interventions are recommended for 1 to 2 visits for education. This education is to be utilized for at home exercises which include stretching, relaxation, strengthening exercises, etc. There is no documentation to indicate that the sessions provided cannot be done independently by the claimant at home. In this case, the claimant has undergone an unknown amount of therapy in the past. The surgeries were not recent. The request for additional 12 sessions of therapy exceed the guidelines recommended amount and is not medically necessary.

**Water therapy, twice weekly for six weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines aqua therapy Page(s): 22.

**Decision rationale:** Aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The length of treatment recommended is up to 8 sessions. In this case, there is not an indication of inability to perform land-based exercises. The amount requested exceeds the amount suggested by the guidelines. The request above is not medically necessary.

**Three-month rental of an interferential stimulator: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines IF unit Page(s): 118.

**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, there is no formal plan to return to work or exercise plan. In addition, a 1 month trial to determine efficacy is within guidelines for stimulation units like a TENS. The request for 3 month IF trial is not medically necessary.