

<b>Case Number:</b>	CM15-0173707		
<b>Date Assigned:</b>	09/16/2015	<b>Date of Injury:</b>	01/29/2014
<b>Decision Date:</b>	10/19/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2015

### 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: 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 47 year old female, who sustained an industrial injury on 01-29-2014. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for high cholesterol, chronic low back pain with radicular symptoms, right shoulder and upper extremity pain, left hand pain, right knee pain, and anxiety. Medical records (02-05-2015 to 07-16-2015) indicate ongoing low back pain with radiating pain into the right lower extremity and associated with numbness and tingling. The IW's pain has consistently been rated as 5-8 out of 10 with no significant changes in these exams. Records also indicate no changes in activities of daily living. Per the primary treating physician's progress report (PR), the IW has not returned to work. The physical exams, dated 06-18-2015 and 07-16-2015, revealed ongoing diffuse tenderness over the lumbar paraspinal muscles, moderate facet tenderness in L4-S1, continued restricted range of motion in the lumbar spine, positive Fabere's-Patrick's tests on the right, positive sacroiliac tenderness and trust test on the right, positive Yeoman's test on the right, positive Kemp's test bilaterally, positive supine and seated straight leg raises bilaterally, and diminished sensation in the L4-S1 dermatomes. There were no changes in these exam findings. Relevant treatments have included physical therapy (PT), work restrictions, and medications. There was a MRI of the lumbar spine, dated 04-2014, available for review which showed L4-5 degenerative disc disease with a 2mm disc protrusion, but no central or foraminal stenosis. A MRI of the lumbar spine was completed on 06-03-2015 and showed an increased in the L4-5 disc protrusion (to 4.2mm) that is flattened and abuts that anterior portion of the thecal sac with mild bilateral lateral spinal and neural foraminal stenosis, and a new 3.0mm annular concentric

broad-based disc protrusion abutting the anterior portion of the theca sac with mild bilateral lateral spinal and neural foraminal stenosis. The pain management PR (04-02-2015) shows that the following equipment and testing were originally requested on 03-05-2015: IF (interferential) unit for 30 day home use trial and a MRI of the lumbar spine. The original utilization review (08- 20-2015) denied the request for unit for 30 day home use trial (specific reasons not clear), and denied the request for a MRI of the lumbar spine based on the lack of worsening symptoms.

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

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

**Interferential unit 30 days trial for home use:** Overturned

**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): Electrical stimulators (E-stim).

**Decision rationale:** The MTUS Guidelines do not recommend an interferential stimulator as an isolated treatment, however it may be useful for a subset of individuals that have not had success with pain medications. The evidence that an interferential stimulator is effective is not well supported in the literature, and studies that show benefit from use of the interferential stimulator are not well designed to clearly demonstrate cause and effect. The guidelines support the use of an interferential stimulator for a one month trial to determine if this treatment modality leads to increased functional improvement, less reported pain and medication reduction. In this case, the individual has had no documented relief from prior physical therapy or pain medications. The request for Interferential unit 30 days trial for home use is determined to be medically necessary.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/MRI (magnetic resonance imaging) Section.

**Decision rationale:** The MTUS Guidelines do not recommend the routine use of MRI with low back complaints. MRI should be reserved for cases where there is physiologic evidence that tissue insult or nerve impairment exists, and the MRI is used to determine the specific cause. MRI is recommended if there is concern for spinal stenosis, cauda equine, tumor, infection or fracture is strongly suspected, and x-rays are negative. The ODG recommends repeat MRI when there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). In this case, the injured worker had a lumbar MRI on 06/03/15 and there is no documentation of worsening symptoms. The request for MRI of the lumbar spine is determined to not be medically necessary.