

<b>Case Number:</b>	CM15-0175177		
<b>Date Assigned:</b>	09/16/2015	<b>Date of Injury:</b>	09/13/2013
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2015

### 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 41 year old male who sustained an industrial injury on 9-13-13. Diagnoses are lumbago and lumbar spine sprain-strain. Previous treatment includes physical therapy, MRI, and medication. In an initial evaluation report and request for authorization dated 7-17-15, the physician notes complaint of constant sharp low back pain. The pain level varies throughout the day with a level of 5-10 out of 10. Pain increases with prolonged standing, twisting, walking, lifting, bending, stooping, squatting and lying on his back. Current medication is Advil. Exam of the lumbar spine reveals point tenderness. It is noted he has pain in the right lower paraspinal area at L5-S1 without significant tenderness. There are no radiculopathy symptoms noted. Straight leg raise testing is negative. It is noted that on 7-3-15, he resigned from his job due to increased low back pain. Work status is that he is able to return to modified work duties with restrictions. The requested treatment of an MRI-lumbar spine, Functional Capacity Evaluation (FCE), acupuncture- lumbar spine twice weekly for 6 weeks, Solace stimulator unit, home exercise kit, and a lumbosacral orthosis (LSO) back brace was non-certified on 8-10-15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The MTUS states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The medical record fails to document sufficient findings indicative of nerve root compromise, which would warrant an MRI of the lumbar spine. MRI of the lumbar spine is not medically necessary.

**Functional Capacity Evaluation (FCE):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty, Functional capacity evaluation (FCE).

**Decision rationale:** The Official Disability Guidelines state that a functional capacity evaluation is appropriate if, case management is hampered by complex issues, and the timing is appropriate; such as if the patient is close to being at maximum medical improvement or additional clarification concerning the patient's functional capacity is needed. Functional capacity evaluations are not needed if the sole purpose is to determine a worker's effort or compliance, or the worker has returned to work. There is no documentation in the medical record to support a functional capacity evaluation based on the above criteria. There are no documented failed return to work attempts. Functional Capacity Evaluation (FCE) is not medically necessary.

**Acupuncture left spine twice weekly for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines state that the initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments would be predicated upon documentation of functional improvement. The request for 12 treatments is greater than the number recommended for a trial to determine efficacy. Acupuncture left spine twice weekly for six weeks is not medically necessary.

**Solace stim unit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Neuromuscular electrical stimulators (NMES).

**Decision rationale:** The Official Disability Guidelines do not recommend neuromuscular electrical stimulation except for spinal cord injured patients. This patient's diagnoses are lumbago and spine strain/sprain. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. Solace stim unit is not medically necessary.

**Home exercise kit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

**Decision rationale:** The MTUS and the Official Disability Guidelines are silent on this issue. According to the Blue Cross Clinical UM Guideline, health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a doctor are not medically necessary. Home exercise kit is not medically necessary.

**LSO brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Activity.

**Decision rationale:** According to the MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Based on the patient's stated date of injury, the acute phase of the injury has passed. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. LSO brace is not medically necessary.