

<b>Case Number:</b>	CM15-0177851		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	06/25/2015
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	08/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 June 25, 2015. A first report of illness report dated June 25, 2105 reported the worker evaluated and treated under the diagnoses of lumbar muscle strain, initial, and lumbosacral spondylosis. An intramuscular injection of Toradol noted administered this visit. There are noted subjective complaint of back pain, tailbone pain and right shoulder pain. The following medications were dispensed: Pantoprazole, Despramine, Pepcid, Zofran Flexeril, and Astelin. The following day of June 26, 2015 reported the medical impression of lumbosacral strain and sprain and coccyx contusion. Cold pack applied for comfort and the following medications noted prescribed: Acetaminophen ES, Biofreeze gel, and Tramadol. A large cold pack, inflatable donut cushion, and lumbosacral support noted dispensed. She is to continue with physical therapy session. Documentation provided showed on July 28, 2015 an interferential stimulator unit ordered for both trial and purchase with supplies. A doctors' first report of illness dated July 28, 2015 reported subjective complaint of right shoulder, lower back, left hip, left leg and neck pains.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic visits 3 times a week for 4 weeks: Upheld**

**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): Manual therapy & manipulation.

**Decision rationale:** Regarding the request for chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, the currently requested 12 treatment sessions exceeds the initial trial recommended by guidelines of 6 visits. As such, the currently requested chiropractic care is not medically necessary.

**Home interferential unit:** Upheld

**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): Transcutaneous electrotherapy.

**Decision rationale:** Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

**LSO brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar supports.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): General Approach, Initial Assessment, Medical, Work-Relatedness, Initial Care, Physical Methods, Activity. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

**Decision rationale:** Regarding the request for LSO brace, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of the treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested LSO brace is not medically necessary.