

<b>Case Number:</b>	CM15-0070203		
<b>Date Assigned:</b>	04/17/2015	<b>Date of Injury:</b>	05/01/2009
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	04/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/13/2015

### 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: New York  
 Certification(s)/Specialty: Emergency 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 58 year old male who sustained an industrial injury involving his low back and neck on 3/28/2008. He currently complains of constant, sharp pain in the neck and right shoulder. He has noted numbness and weakness in the arm and paresthesia in the hand. In addition he complains of dull, intermittent low back pain radiating into bilateral lower extremities with numbness and paresthesia. His pain level is 9/10. Medications are Valium, Vicodin ES, tizanidine, Neurontin, Prilosec. Diagnoses include cervical disc displacement; lumbar disc displacement; cervical radiculitis; degeneration of the cervical intervertebral disc; lumbar radiculopathy; low back pain. Treatments to date include ice, medications (non-steroidal anti-inflammatories), rest, heat, physical therapy, lumbar epidural steroid injection, cervical epidural steroid injection (7/8/13) with 50-60% relief. Diagnostics include electromyography/ nerve conduction study which showed L5 radiculopathy; cervical MRI (undated) with disc protrusion. The treating provider's plan of care available for review (3/9/15) does not address the requested treatments that includes re-evaluation with internist, one injection intramuscular Toradol, one new pro-stimulator unit and one back brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Re-evaluation with internist: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Lucas MG, Bedretdinova D, Bosch JLHR, Burkhard F, Cruz F, Nambiar AK, de Ridder DJMK, Tubaro A, Pickard RS. Guidelkines on urinary incontinence. Arnherm (The Netheriands): European Association of Urology (EAU); 2013 Mar. page 11/27 (147 references).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Evidence-Based Criteria Cited By Expert Reviewer: A specific guideline cannot be cited because the requested service was not described in sufficient detail. In order to select the relevant guideline, the requested service must refer to a specific treatment, test, or referral. The request in this case was too generic and might conceivably refer to any number of medical conditions and guideline citations.

**Decision rationale:** The request to Independent Medical Review is for a referral which was not adequately explained. The treating physician did not supply sufficient information regarding the nature of the request and its indications. No internal medicine conditions requiring evaluation were discussed. The purpose of the referral is not clear. The request is not medically necessary based on the lack of sufficient indications and lack of sufficient clinical evaluation.

**1 intramuscular injection of Toradol 2 cc: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory Page(s): 61-65, 71-72.

**Decision rationale:** According to CA MTUS chronic pain guidelines, non-steroidal anti-inflammatory agents are "recommended as an option for short term symptomatic relief" for the treatment of chronic low back pain. Further recommendations are for the lowest dose for a minimal duration of time. Specific recommendations for Toradol state "This medication is not indicated for minor or chronic painful conditions." Additionally, the request does include frequency and dosing of this medication. The request is not medically necessary.

**1 New Pro-stim unit 5.0 unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Interferential Current Stimulation (ICS) Galvanic Stimulation, Neuromuscular electrical stimulation (NMES devices).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** The CA MTUS ACOEM guidelines recommend against the use of TENS units for the management of low back complaints. Additionally, the chronic pain management guidelines recommend against this therapy as a primary treatment, but support a one month home based trial. The IW has had the unit for at least several months according the record. The documentation supports ongoing use of a stimulator device. Specific benefits related to the use of the unit are not discussed. Without this documentation, the request for a new unit is not medically necessary.

**1 back brace (quick draw):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & chronic).

**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 pain - lumbar supports.

**Decision rationale:** The CA MTUS ACOEM guidelines recommend against the use of TENS units for the management of low back complaints. Additionally, the chronic pain management guidelines recommend against this therapy as a primary treatment, but support a one month home based trial. The IW has had the unit for at least several months according the record. The documentation supports ongoing use of a stimulator device. Specific benefits related to the use of the unit are not discussed. Without this documentation, the request for a new unit is not medically necessary.