

<b>Case Number:</b>	CM15-0076837		
<b>Date Assigned:</b>	04/28/2015	<b>Date of Injury:</b>	07/21/2014
<b>Decision Date:</b>	06/29/2015	<b>UR Denial Date:</b>	04/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2015

### 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: Texas, 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 is a 51-year-old male patient, who sustained an industrial injury on 7/21/14. The diagnoses include lumbar disc herniation. Per the PR-2 note dated 3/23/15 he had complains of continued low back pain. The pain was minimal and may increase with forward bending, standing for 10 minutes and lying face down. Physical examination revealed moderate tenderness elicited to the lumbar paraspinal region with +2/2 upper and lower extremity. Range of motion testing- mild decreased flexion 60/80 degrees. The medications list includes naproxen. He has had MRI lumbar spine on 10/10/14. Treatment to date has included 8 chiropractic therapy; 9 physical therapy visits and 6 acupuncture visits for this injury. The provider has requested: physical therapy 2 times a week for 6 weeks for lumbar, lumbar support and IF unit and STP consult/Acupuncture 2 times a week for 6 weeks for lumbar.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 6 weeks for lumbar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy Page(s): 98.

**Decision rationale:** Physical therapy 2 times a week for 6 weeks for lumbar. The cited guidelines recommend up to 9-10 physical therapy visits for this diagnosis. Per the records provided, patient has had 8 chiropractic therapy; 9 physical therapy visits and 6 acupuncture visits for this injury. The requested additional visits in addition to the previously physical therapy sessions are more than recommended by the cited criteria. There is no evidence of significant progressive functional improvement from the previous physical therapy visits that is documented in the records provided. Per the cited guidelines, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of Physical therapy 2 times a week for 6 weeks for lumbar is not established for this patient at this time.

**DME: lumbar support:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Work relatedness Page 298.

**Decision rationale:** DME: lumbar support. Per the ACOEM guidelines "There is no evidence for the effectiveness of lumbar supports." Therefore, cited guidelines do not recommend lumbar support for low back pain. Evidence of a recent lumbar fracture, spondylolisthesis, recent lumbar surgery or instability is not specified in the records provided. In addition, response to previous conservative therapy including physical therapy and pharmacotherapy was not specified in the records provided. Intolerance or lack of response to oral medications was not specified. The medical necessity of DME: lumbar support is not fully established for this patient.

**DME: IF unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ICS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS)Page 118-120.

**Decision rationale:** DME: IF unit. Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) 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." Per the cited guideline "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications. Pain is ineffectively controlled with medications due to side

effects. History of substance abuse. Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment. Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)."There is no evidence of failure of conservative measures like physical therapy or pharmacotherapy for this patient. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse is not specified in the records provided. The medical necessity of DME: IF unit is not fully established for this patient at this juncture.

**STP consult/Acupuncture 2 times a week for 6 weeks for lumbar: Upheld**

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

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

**Decision rationale:** STP consult/Acupuncture 2 times a week for 6 weeks for lumbar. MTUS guidelines, Acupuncture Medical Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines. CA MTUS Acupuncture medical treatment guidelines cited below state that "Acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery." CA MTUS Acupuncture guidelines recommend up to 3 to 6 treatments over 1 to 2 months for chronic pain. Per the cited guidelines, "Acupuncture treatments may be extended if functional improvement is documented." Per the records provided, patient has had 8 chiropractic therapy; 9 physical therapy visits and 6 acupuncture visits for this injury. There is no evidence of significant progressive functional improvement from the previous acupuncture visits that is documented in the records provided. The medical records provided do not specify any intolerance to pain medications. Response to previous conservative therapy including physical therapy and pharmacotherapy is not specified in the records provided. The records submitted contain no accompanying current physical therapy/acupuncture evaluation for this patient. The medical necessity of STP consult/Acupuncture 2 times a week for 6 weeks for lumbar is not fully established in this patient at this time.