

<b>Case Number:</b>	CM14-0005482		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	02/24/2008
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	12/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 64 year old female who sustained an injury to her low back on 02/24/08. Mechanism of injury was not documented. The injured worker has completed an extensive amount of post-operative physical therapy following L5-S1 laminectomy/discectomy in 1998. Magnetic resonance image of the lumbar spine dated 03/12/09 reportedly revealed post-operative changes at L5-S1 without evidence for recurrent or residual disc protrusions. Per progress note dated 12/06/13, the injured worker continued to complain of low back pain that was constant, achy, sore, and pressure-like at 7-8/10 visual analog scale (VAS). She reported a gripping sensation in the low back/buttocks that woke her up at night and radiated down to the posterior thighs with associated numbness in the calf and foot. Physical examination no moderate tenderness to palpation at the lumbosacral and sacroiliac joint; range of motion limited in all directions; pain with oblique extension; muscle strength 5/5 in the lower extremities, except for right hip flexion at 4+/5 and big toe extension at 4/5; decreased sensation to pin prick in L5 and S1 levels of the dermatomal distribution; deep tendon reflexes 1+ at bilateral knees and trace at bilateral ankles.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS UNIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, CHRONIC PAIN (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION) Page(s): 114-116.

**Decision rationale:** There was also no documentation of adjunctive participation in an exercise program. There was no specific documentation regarding how much transcutaneous electrical nerve stimulation (TENS) alleviates pain, improves function, and decreases need for other treatment including medications. The Chronic Pain Medical Treatment Guidelines states that while TENS may reflect the longstanding reflected standard of care within many medical communities, the resultant studies are inconclusive; published trials do not provide information on stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long term effectiveness. Several published evidence based assessments of TENS have found that evidence is lacking concerning effectiveness. Given this, the request is not indicated as medically necessary.

**MRI(MAGNETIC RESONANCE IMAGING) OF LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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 CHAPTER, MRIS (MAGNETIC RESONANCE IMAGING).

**Decision rationale:** There was no documentation of any new 'red flag' neurological symptoms or findings. There was no documentation of suspicion of spinal fracture, infection, or neoplasm. There was no mention that a surgical intervention was anticipated. After reviewing the clinical documentation submitted for review, there was no additional significant objective information provided that would support reverse of the previous adverse determination. Given this, the request for magnetic resonance image of the lumbar spine is not indicated as medically necessary.