

<b>Case Number:</b>	CM14-0040961		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	03/13/2000
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	04/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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 and is licensed to practice in California. 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:

This case involves 67 year old injured worker who sustained an injury on 3/13/200 while employed by [REDACTED]. Request (s) under consideration includes Transcutaneous Electrical Nerve Stimulation (TENS) unit replacement and lumbar orthosis waist (size 8). Diagnosis includes lumbar radiculopathy; chronic pain; anterolisthesis L3-4; annular tear L5-S1; and gastroesophageal reflux disease (GERD). MRI of the lumbar spine dated 05/21/2011 showed L1-2 disc collapse with minimal bulging; multilevel facet hypertrophy with lateral recess encroachment, spinal; and neural foraminal stenosis. Report dated 03/19/2014 from treating provided noted the patient had ongoing complaints of low back pain rated at 6-7/10 radiating to the bilateral lower extremities. Conservative care has included TENS unit (malfunctioned 2 years ago), lumbar epidural steroid injections, medications, chiropractic treatment, and modified activities/rest. Current medications are Celebrex, Prilosec, Tramadol, Cyclobenzaprine, Alprazolam, Atenolol, and Actonel. The examination showed limited lumbar range from pain, normal deep tendon reflexes on the right and decreased on the left. He had normal motor strength on the right lower extremities and decreased strength on the left lower extremities. His straight leg raise was positive at 50 degrees and normal sensory in bilateral lower extremities. Treatment included ongoing education, strength training, progressive walking, lumbar orthosis, and TENS unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS Unit Replacement:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Transcutaneous Electrotherapy Chronic Medical Treatment Guidelines, TENS, Chronic Pain (Transcutaneous Electrical Nerve Stimulation) Page(s): 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain Page(s): 114-117.

**Decision rationale:** Request for transcutaneous electrical nerve stimulation (TENS) Unit Replacement was non-certified on 4/2/14. Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried, such as medication. The patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, epidural steroid injections, activity modifications, along with previous TENS unit. However, the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in work status, increased in activities of daily living (ADLs), decreased Visual Analog Scale (VAS) score, medication usage, or treatment utilization from the therapy treatment already rendered. The TENS Unit Replacement is not medically necessary.

**Lumbar Orthosis waist 24 (size 8):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Back brace, page 372.

**Decision rationale:** The request for lumbar orthosis waist 24 (size 8) was non-certified on 4/2/14. There are no presented diagnoses of instability, compression fracture, or spondylolisthesis with spinal precautions to warrant a back brace for chronic low back pain. Reports have not adequately demonstrated the medical indication for the Lumbar Sacral Orthosis (LSO). Based on the information provided, the peer-reviewed, nationally recognized guidelines, the request for an LSO cannot be medically recommended. CA MTUS notes lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This patient is well beyond the acute phase of his 2000 injury. In addition, Official Disability Guidelines (ODG) states that lumbar supports are not recommended for prevention; is under study for treatment of nonspecific low back pain; and only recommended as an option for

compression fractures, specific treatment of spondylolisthesis, documented instability, or post-operative treatment. Submitted reports have not adequately demonstrated indication or support for the request beyond guideline recommendations and criteria. The Lumbar Orthosis waist 24 (size 8) is not medically necessary and appropriate.