

Case Number:	CM14-0178784		
Date Assigned:	11/03/2014	Date of Injury:	04/13/2014
Decision Date:	01/13/2015	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	10/28/2014

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 & Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 56 year old female with an injury date of 04/13/14. Based on the 04/24/14 progress report, the patient complains of mid back pain and low back pain. In regards to the lumbar spine, the patient has right sided muscle spasm and painful flexion/extension. The 08/06/14 report states that the patient continues to have back pain and weakness. No additional positive exam findings were provided on the 08/06/14 report. The 09/12/14 report indicates that the patient rates her low back pain as an 8/10 with lower extremity symptoms. Her lumbar spine is tender and she has a "positive straight leg raise for pain to foot at 35 degrees." The patient's diagnoses include the following: 1) 6 mm protrusion L5-S1 with right neural encroachment, 2) Lumbar radiculopathy, 3) Lumbar sprain/strain. The utilization review determination being challenged is dated 10/24/14. There were three treatment reports provided from 04/24/14, 08/06/14, and 09/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro LSO: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back chapter

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 Chapter, lumbar supports

Decision rationale: According to the 09/12/14 report, the patient presents with low back pain which she rates as an 8/10. The request is for Retro LSO to provide stability and facilitate improved tolerance to standing and walking. ACOEM Guidelines page 301 on lumbar bracing state, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under its Low Back Chapter, lumbar supports states, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment ODG further states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." The patient is diagnosed with a 6 mm protrusion L5-S1 with right neural encroachment, lumbar radiculopathy, and lumbar sprain/strain. The treater documents that the patient needs the LSO brace to "provide stability and facilitate improved tolerance to standing and walking." However, ACOEM and ODG do not support lumbar support unless there is documented spondylolisthesis, instability, fracture, etc. For non-specific back pain, only very-low quality evidence is present. Therefore, the requested LSO brace is not medically necessary.

Continue TENS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116.

Decision rationale: According to the 09/12/14 report, the injured worker presents with low back pain which she rates as an 8/10. The request is for Continue TENS. The 09/12/14 report states that the injured worker has failed physical therapy, home exercise, activity modification. TENS facilitates diminished in pain and improve tolerance to a variety of activity." Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality, but a 1-month home based trial may be consider for a specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, and multiple scoliosis. When a TENS unit is indicated, a 30-home trial is recommended and with documentation of functional improvement, additional usage may be indicated. The patient has reported that the TENS unit has decreased the patient's pain and improved her tolerance to a variety of activities. However, there is no discussion regarding frequency of use, magnitude of pain reduction, and any functional changes with utilizing the TENS unit. MTUS allows for extended use of the unit when there is documentation of functional improvement. The requested TENS unit is not medically necessary.

