

<b>Case Number:</b>	CM15-0101051		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	10/02/2010
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 42-year-old male, with a reported date of injury of 10/02/2010. The diagnoses include lumbar sprain/strain, lumbar paraspinal muscle spasm, multiple lumbar disc herniation, lumbar radiculitis/radiculopathy of lower extremities, chronic pain, and sacroiliitis of bilateral sacroiliac joint. Treatments to date have included an MRI of the lumbar spine on 09/19/2013, oral medications, bilateral L4-5 and L5-S1 transforaminal cannulation of lumbar epidural space on 03/25/2015, and left sacroiliac joint injection under fluoroscopic guidance on 04/01/2015. The progress report dated 04/23/2015 indicates that the injured worker had low back pain with limited range of motion and tingling and numbness to the right leg. It was also noted that he had severe paraspinal muscle spasm. The injured worker complained of pain over the right buttock with radiation to the posterior and lateral aspect of the right thigh with numbness and tingling progressively increasing in severity. The objective findings include weakness with tingling and numbness in the right leg, severe paraspinal muscle spasm, and severe sacroiliac joint inflammation with signs and symptoms of radiculitis/radiculopathy to the posterior and lateral aspect of the thigh. The treating physician requested lumbar back support, an H-wave unit due to limited impairment on TENS (transcutaneous electrical nerve stimulation) unit, and percutaneous neurostimulator treatments based on progressive radiculitis/radiculopathy to the lower extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar back support:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 138-139, 300-301, Chronic Pain Treatment Guidelines Page(s): 98.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** Per the MTUS Guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The clinical documents do not report an acute injury that may benefit from short term use of a lumbar support for symptom relief. The MTUS Guidelines do not indicate that the use of a lumbar spine brace would improve function. The request for lumbar back support is determined to not be medically necessary.

**H-wave unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave Stimulation (HWT) Section Page(s): 117-118.

**Decision rationale:** The MTUS Guidelines do not recommend the use of H-wave stimulation as an isolated intervention. A one-month home-based trial of H-wave stimulation may be considered as a noninvasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including physical therapy and medications, plus transcutaneous electrical nerve stimulation. There is no evidence of other co-existing attempts at conservative measures such as exercise. Additionally, it is unclear if this request is for a rental or purchase and for how long. The request for H-wave unit is determined to not be medically necessary.

**Percutaneous neurostimulator treatments once a week for 4 weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), PENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation (PENS) Section Page(s): 97.

**Decision rationale:** Per the MTUS Guidelines, the use of percutaneous electrical nerve stimulation (PENS) is not recommended as a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and

failed or are judged to be unsuitable or contraindicated. There is a lack of high quality evidence to prove long-term efficacy. Percutaneous electrical nerve stimulation (PENS) is similar in concept to transcutaneous electrical nerve stimulation (TENS) but differs in that needles are inserted to a depth of 1 to 4 cm either around or immediately adjacent to the nerve serving the painful area and then stimulated. PENS is generally reserved for patients who fail to get pain relief from TENS, apparently due to obvious physical barriers to the conduction of the electrical stimulation (e.g., scar tissue, obesity). There is no indication of use of more active modalities such as exercise, therefore the request for percutaneous neurostimulator treatments once a week for 4 weeks is determined to not be medically necessary.