

<b>Case Number:</b>	CM15-0146218		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	01/17/2011
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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:

The injured worker is a 52 year old male who sustained a work related injury January 17, 2011. While placing twelve foot bar in a machine, the stand kicked out and pulled his right arm, which he felt tear. Past history included right knee arthroscopy, abrasive chondroplasty with micro-fracturing of femur patella and tibia, arthroscopic partial medial and lateral meniscectomy December, 2013. An MRI of the right shoulder performed April 12, 2011, revealed post-surgical changes at the distal clavicle and acromion, suggestive of prior subacromial decompression; mild tendinosis of the supraspinatus and subscapularis tendons, without evidence of rotator cuff tear. According to a primary treating physician's progress report, dated June 19, 2015, the injured worker presented with chronic and severe lumbar back pain with stiffness and decreased range of motion. The symptoms are located in the low back, left mid back, left sacroiliac region, right low back and right sacroiliac region, and left side more than right. Hawkins Kennedy and Neer's impingement tests are positive right. Apley's scratch test is positive, biceps load test positive and biceps tension test positive. There is moderate tenderness of the right patella anterior-lateral-medial aspect and over the lateral and medial joint line and over the patella. Diagnoses joint stiffness other shoulder; superior glenoid labrum lesion; villonodular synovitis shoulder; bicipital tenosynovitis; rotator cuff tear; tear medial and lateral meniscus knee; chondromalacia patellae. Treatment plan included physical therapy for the lumbar spine, referral to pain management, adult cane, knee brace, MRI of the right shoulder, and at issue, the request for authorization for a TENS(transcutaneous electrical nerve stimulation) unit(indefinite use) and a lumbar back brace. The patient had received an unspecified number of the PT, chiropractic and aquatic therapy visits

for this injury. The patient had used a knee brace and cane for this injury. Per the note dated 5/15/15 the patient had complaints of pain in neck and knee. Physical examination of the lumbar spine revealed 4/5 strength, tenderness on palpation, 2+ effusion, and limited range of motion. The medication list includes Motrin. The patient has had MRI of the lumbar spine on 3/5/13 that revealed foraminal narrowing, and degenerative changes. The patient's surgical history includes right shoulder and right knee surgery.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**TENS (Indefinite use) QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, transcutaneous electrotherapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) page 114.

**Decision rationale:** According the cited guidelines, electrical stimulation (TENS), is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness". Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)". According the cited guidelines, Criteria for the use of TENS is "- There is evidence that other appropriate pain modalities have been tried (including medication) and failed". A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted" Any evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. A detailed response to previous conservative therapy was not specified in the records provided. Previous conservative therapy notes were not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the TENS unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use TENS as an adjunct to a program of evidence-based functional restoration. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse was not specified in the records provided. The request for TENS (Indefinite use) QTY: 1 is not medically necessary or fully established for this patient.

**Back brace (Indefinite use), lumbar QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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 (updated 07/17/15) Lumbar supports.

**Decision rationale:** Per the ACOEM guidelines cited below "There is no evidence for the effectiveness of lumbar supports in preventing back pain in industry". In addition per the ODG cited below regarding lumbar supports/brace, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain Treatment: 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). Under study for post-operative use; see Back brace, post operative (fusion)". Patient has received an unspecified number of PT visits for this injury. Response to prior conservative therapy was not specified in the records provided. Prior conservative therapy notes were not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. There is no evidence of instability, spondylolisthesis, lumbar fracture or recent lumbar surgery. Any evidence of recent back surgery or procedure was not specified in the records provided. The request of Back brace (Indefinite use), lumbar QTY: 1 is not medically necessary or fully established.