

<b>Case Number:</b>	CM15-0168898		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	02/27/1999
<b>Decision Date:</b>	10/07/2015	<b>UR Denial Date:</b>	08/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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: North Carolina

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 an industrial injury on 2-27-99. Initial complaint was of his low back. The injured worker was diagnosed as having lumbar discogenic disease L4-5 and L5-S1; right lower extremity radiculopathy. Treatment to date has included medications. Diagnostics studies included MRI lumbar spine (4-13-15). Currently, the PR-2 notes dated 5-20-15 indicated the injured worker complains of severe low back pain and right leg pain. He reports the pain is worse in the morning but continues to work his daily job duties. He reports doing stretches to loosen up his back and getting an ergonomic work station. He has been treated conservatively with over-the-counter medications and would like to avoid surgery at this time. On physical examination of the lumbar spine, he has pain in the lower back to the right buttock, right sciatic notch area down to the S1. IT is positive at 80 degrees on the right and negative on the left at 90 degrees. He has tenderness to palpation over the facets joints. A MRI of the lumbar spine was done on 4-13-15 with an impression of broad-based disc herniations at L2-3 and L3-4. The herniations abut the thecal sac. L4-5 notes grade I degenerative spondylolisthesis of L4 and L5-S1 retrolisthesis of L5. Combined with facet and ligamentum flavum hypertrophy there is spinal canal narrowing as well as bilateral neuroforaminal narrowing at each of these levels. PR-2 notes dated 2-10-15 indicate the injured worker has an IDET procedure in 2001 at L5-S1. He has had no surgical intervention over the course of his injury but treated with Naprosyn and Motrin. The note indicates he may be a candidate for epidural injections but there is no documentation of a request or authorization for this type of treatment. A Request for Authorization is dated 9-17-15. A Utilization Review letter is dated 8-12-1 and non-certification was for a 4 Lead TENS Unit (in days, quantity 30 and an Inversion Table (indefinite

use). The provider is requesting authorization of 4 Lead TENS Unit (in days) for pain and muscle spasms, quantity 30 and an Inversion Table (indefinite use).

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

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

#### **4 Lead TENS Unit (in days), QTY: 30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** The California chronic pain medical treatment guidelines section on transcutaneous electrical nerve stimulation states: TENS, chronic pain (transcutaneous electrical nerve stimulation). 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. (Carroll-Cochrane, 2001) Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. One problem with current studies is that many only evaluated single-dose treatment, which may not reflect the use of this modality in a clinical setting. Other problems include statistical methodology, small sample size, influence of placebo effect, and difficulty comparing the different outcomes that were measured. This treatment option is recommended as an adjunct to a program of evidence based functional restoration. In addition there must be a 30 day trial with objective measurements of improvement. These criteria have not been met in the review of the provided clinical documentation and the request is not medically necessary.

#### **Inversion Table (indefinite use), QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) durable medical equipment.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use i.e. can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The requested DME does not serve a purpose that cannot be accomplished without it. The prescribed equipment does not meet the standards of DME per the ODG. Therefore, the request is not medically necessary.