

<b>Case Number:</b>	CM15-0183441		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	02/29/2004
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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 59 year old male, who sustained an industrial injury on 2-29-04. The injured worker was diagnosed as having right shoulder pain status post right shoulder rotator cuff repair, acromioplasty (5-25-05) residual pain; right wrist, forearm and elbow tendinitis; right carpal tunnel syndrome; right cubital tunnel syndrome; insomnia secondary to anxiety due to chronic pain; upper back-thoracic strain with thoracic radiculopathy radiating pain to anterior chest wall; secondary depression due to chronic pain; lumbar radiculopathy greater right than left. Treatment to date has included physical therapy; medications. Currently, the PR-2 notes dated 7-23-15 indicated the injured worker was seen on this date for a re-examination. The provider documents 'Overall the patient's symptoms remain persistent. The patient has a history of right upper extremity pain that he describes as 8 out of 10 and thoracic spine discomfort that he rates as 8 out of 10 and low back and right shoulder pain that is 8 out of 10. Physical therapy authorization is still pending at this time. He continues with current medication regimen, which does not mitigate his pain and allow him to continue with his activities of daily living independently. The patient reports he lost his house to a fire a few weeks ago and his back braces as well as TENS unit were lost in the house fire, we will request new ones as these were beneficial in mitigating his pain.' The injured worker reports his current complaints as: 1) right shoulder pain, increased by at or above shoulder level reaching or strenuous activity. 2) right wrist, elbow, hand pain and numbness, increased by repetitive activity or forceful gripping. 3) Mid back pain and upper back pain with radiation to the anterior chest wall. 4) Anxiety, insomnia, and depression due to pain. 5) Low back pain with radiation to the right leg with

burning. The provider notes "With pain medications the pain level is 4-5 out of 10 and without medication it would be 10 out of 10. The medication does allow the patient to do activities of daily living. The patient denies any side effects or any aberrant behavior. The opioid medication is only prescribed by my office. The medications do last 30 days or even longer at times and the patient does not require early refills." A physical examination is documented by the provider noting, "The patient's gait is slow due to low back pain. He used a cane to ambulate. The patient's mood and affect are mildly depressed. Lumbar Spine: Inspection is negative. Palpation of paralumbar muscles showed slight to moderate muscle spasm or tightness greater on the right than the left. Flexion is 70% of normal; extension 50% of normal; right lateral flexion 70% of normal; left lateral flexion is 80% of normal. Straight leg raising test is positive on the right at 70 degrees in sitting and supine position producing buttock and posterior thigh pain; the left side is negative. Inspection of the thoracic spine is negative. Palpation shows tenderness of T3 through T7 parathoracic region with spasm of parathoracic muscles. Thoracolumbar flexion is 60% of normal; extension is 50%; lateral thoracic rotation is 80% bilaterally. The shoulder exam: there is a surgical scar noted. Palpation reveals tenderness of the subacromial and deltoid area. Right shoulder flexion and abduction are 100 degrees. There is slight tenderness of the right volar wrist and tenderness of the flexor and extensor muscles of the right forearm. There is swelling and edema in the right forearm and hand. Tinel's sign is negative at the right wrist but positive at the medial right elbow with paresthesia of the medial forearm and fifth digit. Phalen's test is positive at the right wrist, producing paresthesia of all the digits at 25 seconds. It is negative on the left. The right wrist and hand have normal range of motion but are done slower than the left." A Request for Authorization is dated 9-17-15. A Utilization Review letter is dated 8-20-15 and non-certification was for a Back Brace and TENS unit. The Utilization Review letter notes a telephone conversation took place with the provider's office staff stating "confirmed that the requested back brace and TENS unit are replacements as the claimant had a house fire several weeks ago that destroyed most everything the claimant had including the back brace and TENS unit." The Utilization Reviewer once again made an attempt to speak with the provider of services and again left a message requesting the provider return the call. Utilization Review denied the requested treatments for not meeting the CA MTUS and ODG Guidelines. The medication list include Norco, Naproxen, Lunesta, Pantoprazole and Xanax. A request for authorization has been received for a Back Brace and TENS unit.

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

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

**Back brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 09/22/15), Lumbar supports.

**Decision rationale:** Request Back brace. MTUS Guidelines, American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, 2004 Chapter 12 back complaints page

301. Per the ACOEM guidelines cited below, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." 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. A surgery or procedure note related to this injury was not specified in the records provided. The medical necessity of back brace is not fully established. Therefore, the request is not medically necessary.

**TENS unit:** 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:** TENS unit. 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." 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. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The request for TENS unit is not fully established for this patient. Therefore, the request is not medically necessary.