

<b>Case Number:</b>	CM15-0184917		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	06/18/2012
<b>Decision Date:</b>	11/03/2015	<b>UR Denial Date:</b>	08/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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 60 year old male, who sustained an industrial injury on June 18, 2012. Medical records indicate that the injured worker is undergoing treatment for left sciatica, lumbar disc bulge and lumbosacral interspinous ligament inflammation. The injured worker was working with restrictions. On (8-12-15) the injured worker complained of low back pain. Examination of the lumbar spine revealed slight to moderated tenderness and muscle spasm over the paraspinal muscles. The injured worker noted slight pain in the low back and legs with forward flexion. Forward flexion was 52 degrees. Treatment and evaluation to date has included medications, x-rays of the lumbar spine, MRI, electrodiagnostic studies, urine drug screen, Cortisone injection, transcutaneous electrical nerve stimulation unit, physical therapy, back brace and chiropractic treatments. Current medications include Vicodin, Benazepril and Pravastatin. The treating physician recommended a new MRI of the lumbar spine to rule out worsening lumbosacral disc herniations. The request for authorization dated 8-15-15 includes requests for an MRI of the lumbar spine and transcutaneous electrical nerve stimulation unit electrodes for 6 months. The Utilization Review documentation dated 8-27-15 non-certified the request for an MRI of the lumbar spine and transcutaneous electrical nerve stimulation unit electrodes for 6 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **MRI Of The Lumbar Spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/MRI (magnetic resonance imaging) Section.

**Decision rationale:** The MTUS Guidelines do not recommend the routine use of MRI with low back complaints. MRI should be reserved for cases where there is physiologic evidence that tissue insult or nerve impairment exists, and the MRI is used to determine the specific cause. MRI is recommended if there is concern for spinal stenosis, cauda equine, tumor, infection or fracture is strongly suspected, and x-rays are negative. The ODG recommends repeat MRI when there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). In this case, the injured worker had 2 previous MRIs in June and August of 2105. There is no evidence of interval changes that would warrant a repeat MRI. The request for MRI of the lumbar spine is determined to not be medically necessary.

## **TENS Electrodes For 6 Months: 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 use of TENS for chronic pain is not recommended by the MTUS Guidelines as a primary treatment modality, but a one-month home-based TENS trial may be considered if used as an adjunct to a program of evidence-based functional restoration in certain conditions. A home based treatment trial of one month may be appropriate for neuropathic pain and CRPS II and for CRPS I. There is some evidence for use with neuropathic pain, including diabetic neuropathy and post-herpetic neuralgia. There is some evidence to support use with phantom limb pain. TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. It may be useful in treating MS patients with pain and muscle spasm. The criteria for use of TENS include chronic intractable pain (for one of the conditions noted above) with documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a one month trial period of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used as well as outcomes in terms of pain relief and function, and a treatment plan including specific short and long term goals of treatment. In this case, there is no documentation of the use of TENS and/or the efficacy of the treatment, therefore the request for electrodes is not supported. The request for TENS electrodes for 6 months is determined to not be medically necessary.

