MAXIMUS Federal Services

Case Number:	CM15-0187496		
Date Assigned:	09/29/2015	Date of Injury:	03/12/2003
Decision Date:	11/12/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/23/2015

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 43 year old male who sustained an industrial injury on 03-12-2003. Medical records indicated the worker was treated for back stiffness and pain. In the provider notes of 09-08-2015, the injured worker complains of pain that worsens with extension, flexion and hip extension and flexion. The pain is described as aching, burning, severe, stabbing, throbbing, shooting, and spasming located in the lumbar area, lower back, right and left leg. It is rated as a 4 on a scale of 1-10. Medications include Norco for pain. The medication list includes Advair, Fetzima (levomilnacipran ER), Klonopin, Norco, Fortesta (testosterone), Opana, and Promethazine. The worker notes continued and substantial benefit of medications and has no evidence of drug abuse or diversion or aberrant behavior or medication reactions. Urine drug screens have been appropriate to the medications prescribed. His medications give about a 90% improvement in his pain and attempts to wean the medications have resulted in increased pain, suffering, and decreased functional capacity. The worker is continuing to work. On examination, his gait and station and inspection of bones, joints and muscles are unremarkable. Muscle tone is normal. His psychiatric exam reveals a lack of joy in his life, suicidal ideations "all the time" and the worker reports giving his guns to a friend so he wouldn't have that option. Lumbosacral exam reveals positive pelvic thrust, secondary myofascial pain with triggering and ropey fibrotic banding. He has bilateral positive straight leg raise with pain radiating to the buttocks, posterior thigh, medial leg and posterior calf. The patient has had 4/5 strength, decreased sensation in right lower extremity. He has history of chronic lumbosacral spinal pain, both discogenic and facet-mediated, status post microdicscectomy (2003), status post global fusion at L4-5 (10-23-2010),

hardware removal (10-2011) and history of alcohol dependence and comorbid psychiatric disturbance, industrially and temporarily disabled. He has increased pain. The treatment plan includes use of a transcutaneous electrical nerve stimulation (TENS) unit, and a back brace. A request for authorization was submitted for a Fitted back brace and a TENS unit. A utilization review decision 09-16-2015 non-certified the request for a back brace, and issued modified certification for a 1 month trial of a (TENS) unit in order to allow for documentation of functional improvement. The patient has had CT scan of lumbar spine on 11/16/2007 that revealed disc protrusion and degenerative disc disease. The patient had received an unspecified number of conservative treatments for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fitted back brace: Overturned

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

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: Fitted back brace, Per the ACOEM guidelines cited, 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, 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). In the provider notes of 09-08-2015, the injured worker complains of pain that worsens with extension, flexion and hip extension and flexion. The pain is described as aching, burning, severe, stabbing, throbbing, shooting and spasming located in the lumbar area, lower back, right and left leg. It is rated as a 4 on a scale of 1-10. Lumbosacral exam reveals positive pelvic thrust, secondary myofascial pain with triggering and ropey fibrotic banding. He has bilateral positive straight leg raise with pain radiating to the buttocks, posterior thigh, medial leg and posterior calf. The patient has had 4/5 strength, decreased sensation in right lower extremity. The patient has had history of status post microdicscectomy (2003), status post global fusion at L4-5 (10-23-2010), hardware removal (10-2011). The patient has had CT scan of lumbar spine on 11/16/2007 that revealed disc protrusion and degenerative disc disease. The patient has had significant objective findings and history of lumbar fusion surgery. The patient has conditions of the low back which are prone to exacerbations of pain. Per the cited guidelines, a back brace is recommended as an option for nonspecific back pain. The request for fitted back brace is medically necessary and appropriate for this patient at this time.

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. The patient had received an unspecified number of conservative treatments 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 is not medically necessary.