

<b>Case Number:</b>	CM15-0187538		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	06/10/2013
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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: California, 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 41 year old male, who sustained an industrial injury on 6-10-2013. Medical records indicate the worker is undergoing treatment for lumbar disc displacement, lumbar disc herniation with radiculopathy, lumbar disc protrusion and myofascial pain syndrome of the lumbar spine. A recent progress report dated 9-3-2015, reported the injured worker complained of low back pain. Physical examination revealed forward flexion and lateral bending produced pain and pulling, tenderness to palpation of the paraspinal lumbar 2-5 with decreased range of motion. Treatment to date has included physical therapy, 3 lumbar epidural steroid injections, modified work duty and medication management. The physician is requesting ortho stimulation interferential TENS (transcutaneous electrical nerve stimulation) unit and lumbar support belt. On 9-16-2015, the Utilization Review noncertified the request for ortho stimulation interferential TENS (transcutaneous electrical nerve stimulation) unit and lumbar support belt.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ortho Stimulation interferential 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:** CA MTUS Guidelines states that Interferential Current Stimulation (IF) is not recommended as an isolated intervention, A 1 month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of functional restoration. There is no support for the use of TENS therapy for an injury which is greater than 2 years old, as in this case. There is no documentation of a trial use of a TENS or IF unit with a response to the trial as required by guidelines. There is also insufficient evidence of prior use and response to TENS/IF therapy. Therefore the request is not medically necessary or appropriate.

**Lumbar Support Belt:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar Supports.

**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 (lumbar supports).

**Decision rationale:** ACOEM Guidelines state that lumbar supports do not have any lasting benefit beyond the acute phase of symptomatic relief. In this case, the claimant is over 2 years past the acute subacute phase. ODG does not recommend lumbar supports for the prevention of low back pain. Lumbar supports used chronically have been found to be no more useful than nothing at all. Lumbar supports are recommended for compression fractures, spondylolisthesis, and documented instability of the spine, which this patient does not have. Therefore the request is not medically necessary or appropriate.