

<b>Case Number:</b>	CM15-0195347		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	11/03/2014
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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: Arizona, 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:

This is a 58-year-old female with a date of industrial injury 11-03-2014. The medical records indicated the injured worker (IW) was treated for lumbar herniated nucleus pulposus with bilateral lower extremity radiculopathy and medication-induced gastritis. In the progress notes (9-2-15), the IW reported low back pain and equally left posterior leg pain, rated 8 out of 10. She could only stand for about 30 minutes at a time. Medications included Ultracet, Anaprox and Omeprazole. On examination (7-28-15 and 9-2-15 notes), there was tenderness to palpation bilaterally in the lumbar paraspinal musculature with increased muscle rigidity and numerous trigger points were noted. There was decreased range of motion with obvious muscle guarding. Patellar reflexes were 2 out of 4 and Achilles reflexes were 1 out of 4, bilaterally. Muscle testing was 5- out of 5 in the L5 and S1 myotomes, bilaterally. Sensation to pinprick was decreased along the posterolateral thigh and calf in an approximate L5-S1 distribution bilaterally. Straight leg raise in a modified sitting position was positive at 60 degrees, causing radicular symptoms in both lower extremities, greater on the left. Treatments included physical therapy, without benefit; epidural steroid injection (4-1-15), with 50% to 60% benefit for two to three weeks; and TENS unit, which was beneficial during physical therapy. The IW was temporarily totally disabled. The treatment plan included physical therapy, a lumbar support device and seat cushion to relieve pain during car transports and activities of daily living and an IF-TENS unit. A Request for Authorization dated 9-2-15 was received for LSO back brace purchase, Obus seat cushion purchase and interferential - transcutaneous electrical neurostimulation (IF - TENS) unit combo (electrodes, batteries, set up delivery). The Utilization Review on 9-16-15 non-certified

the request for LSO back brace purchase, Obus seat cushion purchase and interferential - transcutaneous electrical neurostimulation (IF-TENS) unit combo (electrodes, batteries, set up delivery).

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

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

**Obus seat cushion purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Durable medical equipment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter and pg 21.

**Decision rationale:** According to the guidelines, DME products qualify if: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. In this case, the seat cushion was more for comfort during transport rather than for medical purposes at home. It is not on the list of approve DME equipment and is not a medical necessity.

**IF/TENS unit combo (electrodes, batteries, set up delivery):** Overturned

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

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

**Decision rationale:** According to the MTUS guidelines, a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. It is recommended for the following diagnoses: CRPS, multiple sclerosis, spasticity due to spinal cord injury and neuropathic pain due to diabetes or herpes. According to the guidelines an IF unit is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. In this case the claimant does have muscle rigidity and radicular symptoms. There is a plan for adjunctive therapy /exercise plan. The request for a 1 month trial of TENS/IF unit is medically necessary.

**LSO back brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Durable medical equipment.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care.

**Decision rationale:** According to the ACOEM guidelines, lumbar supports have not been shown to provided lasting benefit beyond the acute phase of symptom relief. In this case, the claimant's injury was remote and symptoms were chronic. Length of use was not specified. The use of a LSO brace is not medically necessary.