

<b>Case Number:</b>	CM15-0023508		
<b>Date Assigned:</b>	02/13/2015	<b>Date of Injury:</b>	09/08/2014
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/09/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal 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 50 year old male, who sustained an industrial injury on 09/08/2014. He has reported subsequent low back pain radiating to the bilateral lower extremities and was diagnosed with lumbar spine herniated nucleus propulsus with radiculopathy of the bilateral lower extremities. Treatment to date has included oral pain medication, application of ice and physical therapy. In a progress note dated 12/22/2014, the injured worker complained of constant, severe low back pain radiating to the left lower extremity with numbness and tingling and occasional right lower extremity symptoms. Objective physical examination findings were notable for positive tenderness to palpation of the thoracolumbar paraspinal muscles, positive spinous process tenderness, reduced lumbar range of motion and positive bilateral straight leg raise. A request for authorization of a back brace and TENS unit was made. On 01/07/2015, Utilization Review non-certified requests for a back brace and TENS unit, noting that there was limited evidence of extenuating circumstances that necessitate a lumbar brace and that there was no clear indication that the injured worker had received a trial of a TENS unit with physical therapy services with objective and functional benefit. MTUS and ACOEM guidelines were cited.

### 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 ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Low back section, Lumbar supports

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, lumbar supports are not medically necessary. Lumbar supports have not been shown to have lasting effect beyond the acute phase of symptom relief. Lumbar supports are not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. Additionally, lumbar supports do not prevent low back pain. In this case, the injured worker's working diagnosis is lumbar spine herniated disc with radiculopathy, bilateral lower extremities, left greater than right. Lumbar supports have not been shown to have a lasting effect beyond the acute phase of symptom relief. Additionally, lumbar supports are not recommended for prevention. Consequently, according to the guidelines, back brace is not medically necessary.

**TENS (transcutaneous electrical nerve stimulation) Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 116. Decision based on Non-MTUS Citation Pain section, TENS

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, TENS unit is not medically necessary. TENS is not recommended as a primary treatment modality, but a one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, including reductions in medication use. The Official Disability Guidelines enumerate the criteria for the use of TENS. The criteria include, but are not limited to, a one month trial period of the TENS trial should be documented with documentation of how often the unit was used as well as outcomes in terms of pain relief and function; there is evidence that appropriate pain modalities have been tried and failed; other ongoing pain treatment should be documented during the trial including medication usage; specific short and long-term goals should be submitted; etc. See the guidelines for additional details. In this case, the injured worker's working diagnosis is lumbar spine herniated disc with radiculopathy, bilateral lower extremities, left greater than right. The medical record does not contain a one month TENS trial. There is no documentation as to the outcome in terms of pain relief and function and how often the TENS unit was used during the trial period. Additionally, there are no specific short and long-term goals submitted by the treating physician. Consequently, absent clinical documentation with a 30 day TENS trial, TENS unit is not medically necessary.

