

Case Number:	CM15-0041653		
Date Assigned:	03/11/2015	Date of Injury:	07/21/2014
Decision Date:	04/15/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/05/2015

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: 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 37 year old female injured worker suffered an industrial injury on 7/21/2014. The diagnosis was lumbar disc displacement, sprain/strain. The diagnostic study was lumbar magnetic resonance imaging on 15 Dec 2014, which showed mild degenerative disc changes at L5-S1 associated with minor right forminal narrowing. The treatments have included medications, physical therapy (not helpful), acupuncture (not effective after 3 visits) and chiropractic therapy (ongoing). The treating provider reported on 11 Feb 2015 the patient continued to have right buttock and leg pain although has improving low back pain. Examination showed decreased lumbar back range of motion, decreased strength in right hamstring muscle (4/5), positive straight leg raise and reduced sensation in right foot consistent with the L5 dermatome. The provider requested use of LSO brace and MEDS-4 Interferential w/garment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable medical equipment: LSO brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307-8. Decision based on Non-MTUS Citation 1) North American Spine Society (NASS). Diagnosis and treatment of degenerative lumbar spinal stenosis. Burr Ridge (IL): North American Spine Society (NASS); 2011. 104 p. [542 references]2) Canadian Institute of Health Economics: Toward Optimized Practice. Guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2011. 37 p. [39 references].

Decision rationale: A Lumbar-Sacral Orthosis (LSO) Back Brace is a device designed to limit the motion of the spine. It is used in cases of vertebral fracture or in post-operative fusions, as well as a preventative measure against some progressive conditions or for work environments that have a propensity for low back injuries. The patient has none of these indications. The ACOEM guidelines as well as other guidelines do not recommend use of a back brace or corset for treating low back pain as its use is not supported by research-based evidence. When back braces are used any benefits from its use goes away as soon as the brace is removed. Considering the known science and the patient's documented impairments there is no indication for use of a back brace in treating this patient at this time. Medical necessity has not been established.

MEDS-4 Interferential w/garment: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): Chp 3 pg 48-9; Chp 12 pg 300, 308, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-20.

Decision rationale: IF (Inferential Stimulator) units are transcutaneous electrical nerve stimulation (TENS) units that use electric current produced by a device placed on the skin to stimulate the underlying nerves, which can result in lowering acute or chronic pain. It differs from other TENS units in that it modulates a TENS pulse at a higher wavelength. This presumably reduces the capacitance of skin and allows deeper penetration of the electrical currents into the skin. However, there is a lot of conflicting evidence for use of TENS and the MTUS specifically notes that IF therapy is not recommended as an isolated therapy. The MTUS does recommend TENS therapy during the first 30 days of the acute post-surgical period although it notes that its effectiveness for orthopedic surgical procedures is not well supported by the literature. This request for use on an IF unit in this patient is not during the immediate post-surgical period although it is in conjunction with other therapies (medication and chiropractic therapy). The patient has chronic intractable pain and has failed other therapies. This meets the criteria required for its use. Thus, medical necessity for a trial of this therapy has been established.