

<b>Case Number:</b>	CM15-0052392		
<b>Date Assigned:</b>	03/25/2015	<b>Date of Injury:</b>	07/24/2001
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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 66-year-old male, who sustained an industrial injury on 7/24/2001. The current diagnoses are post laminectomy syndrome of the lumbar region and sciatica. According to the progress report dated 2/2/2015, the injured worker complains of low back pain with radiation into the buttocks and down one leg. The average pain level is rated 6-7/10 with medications and 9-10/10 without. The current medications are Vicodin, Naproxen, Zolpidem, Omeprazole, and Ambien. Treatment to date has included medication management, MRI, and surgical intervention. The plan of care includes TLSO brace, TENS unit, and power mobility scooter.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TLSO 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, Lumbar Supports.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, lumbar support.

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, TLSO (thoracolumbar) back brace is not medically necessary. Lumbar supports have not been shown to have lasting benefits beyond the acute phase of symptom relief. Lumbar supports. Lumbar supports are not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing back pain. In this case, the injured worker's working diagnoses are not listed in the March 9, 2015 progress note. The diagnosis section states the injured worker was present for a refill of his medications. The diagnoses from a November 24, 2014 progress note are post laminectomy syndrome lumbar region; sciatica; and unspecified myalgia and myositis. The documentation from a February 2, 2015 progress note does not contain a physical examination of the lumbar spine. Lumbar supports have not been shown to have lasting benefits beyond the acute phase of symptom relief. Lumbar supports. Lumbar supports are not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing back pain. Consequently, absent guideline recommendations for a TLSO (thoracolumbar) back brace, TLSO (thoracolumbar) back brace is not medically necessary.

**TENS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation) Page(s): 114.

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

**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 diagnoses are not listed in the March 9, 2015 progress note. The diagnosis section states the injured worker was present for a refill of his medications. The diagnoses from a November 24, 2014 progress note are post laminectomy syndrome lumbar region; sciatica; and unspecified myalgia and myositis. The documentation pursuant to a February 2, 2015 progress note does not contain a clinical indication or rationale for a TENS unit. The documentation does not indicate the anatomical region for application. There is no documentation of a TENS trial in the medical

record. There are no short and long-term goals documented medical records. Consequently, absent clinical documentation with a TENS trial, clinical indications/rationale and documentation of a TENS unit with specific short and long-term goals, TENS unit is not medically necessary.

**Power mobility scooter:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Device Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Power Mobility Device.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines, a power mobility scooter is not medically necessary. Power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. In this case, the injured workers working diagnoses are not listed in the March 9, 2015 progress note. The diagnosis section states the injured worker was present for a refill of his medications. The diagnoses from a November 24, 2014 progress note are post laminectomy syndrome lumbar region; sciatica; and unspecified myalgia and myositis. Documentation from a March 9, 2015 note shows the injured worker has disabling pain and difficulty ambulating became. The provider indicates the injured worker is not a candidate for a manual wheelchair. However, the physical examination does not demonstrate findings of limited upper extremity function. There is no physical examination in the medical record dated March 9, 2015. Additionally, the injured worker is presently driving an automobile and is able to care for himself with limited assistance. The worker performs like chores around the house. The injured worker presently uses a cane. The guidelines state if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. Consequently, absent clinical documentation of a complete inability to ambulate with the use of an assistive device such as a cane with an inability to drive an automobile and care for himself, a power mobility scooter is not medically necessary.