

<b>Case Number:</b>	CM15-0053105		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	08/19/2013
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2015

### 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: Physical Medicine & Rehabilitation

### 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 43-year-old female who sustained an industrial injury on 08/19/2013. Diagnoses include traumatic left shoulder impingement syndrome with partial to complete tear of rotator cuff-status post left shoulder arthroscopy on 01/20/2015, sacroiliitis of bilateral sacroiliac joints, multiple lumbar disc herniations, lumbar radiculitis/radiculopathy of the lower extremities, and lumbar paraspinal muscle spasm. Treatment to date has included diagnostic studies, medications, left sacroiliac joint injections under fluoroscopic guidance, epidural steroid injections, status post left shoulder arthroscopy, and physical therapy. A physician progress note dated 10/21/2014 documents the injured worker received her second epidural steroid injection and has had a decrease in radicular symptoms, but she has increase in spasm over the calves and toes. Medications help with her pain. She rates her pain as 4 out of 10 since her injection. The lumbar spine has tenderness to palpation over the paraspinal muscle, and has +2 muscle spasms. She has a positive straight leg raise on the left at 45 degrees. Treatment requested is for DME TENS unit for 3 months rental, and Supplies for lumbar back support.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME TENS unit for 3 months rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines criteria for the use of TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

**Decision rationale:** The patient presents with radicular low back pain rated 4/10 and increase in spasm over the calves and toes. The request is for DME TENS UNIT FOR 3 MONTHS RENTAL. The RFA is not provided. Patient's diagnosis included multiple lumbar disc herniations, lumbar radiculitis/radiculopathy of the lower extremities, and lumbar paraspinal muscle spasm. Patient is temporarily partially disabled. According to MTUS guidelines on the criteria for the use of TENS in chronic intractable pain: (p116) "a one-month trial period of the TENS unit should be documented (as an adjunct to other treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function during this trial." Review of the medical reports did not show a prior use of TENS unit. In this case the patient presents with chronic low back and radicular symptoms for which a trial of TENS unit may be indicated. However, MTUS recommends trying one-month home use before proceeding with long term use. The current request for 3 months trial is not within the guidelines. The request IS NOT medically necessary.

**Supplies for lumbar back support:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, Lumbar Supports.

**Decision rationale:** The patient presents with radicular low back pain rated 4/10 and increase in spasm over the calves and toes. The request is for SUPPLIES FOR LUMBAR BACK SUPPORT. The RFA is not provided. Patient's diagnosis included multiple lumbar disc herniations, lumbar radiculitis/radiculopathy of the lower extremities, and lumbar paraspinal muscle spasm. Patient is temporarily partially disabled. ACOEM Guidelines page 301 on lumbar bracing state, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under its low back chapter, Lumbar Supports, states, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment, ODG further states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP - very low-quality evidence, but may be a conservative option." The rationale for the request is not discussed. ODG recommends it as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP. The patient does not present with fracture, documented instability, or spondylolisthesis to warrant lumbar bracing. Furthermore, ACOEM states that lumbar supports have not been shown to have any

lasting benefit beyond the acute phase of symptom relief. In this case, the patient injury date was reported as 08/19/13. The request IS NOT medically necessary.