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| <b>Case Number:</b>   | CM15-0245500 |                              |            |
| <b>Date Assigned:</b> | 12/28/2015   | <b>Date of Injury:</b>       | 09/17/2015 |
| <b>Decision Date:</b> | 01/29/2016   | <b>UR Denial Date:</b>       | 12/10/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/17/2015 |

### 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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

### 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 48 year old male who sustained an industrial injury on 09-17-2015. According to a chiropractic treatment note dated 11-24-2015, the injured worker reported sacrum pain that was severe and getting worse. Pain was rated 10 on a scale of 0-10. Right thigh pain was severe, constant, unchanged and rated 9. Fatigue was moderate severe and remained unchanged since the last visit and was rated 8. Nausea was moderate, occasional and remained unchanged. Objective findings included low back range of motion abnormality and low back pain and tenderness. Diagnoses included intervertebral disc disorders with radiculopathy lumbar region. The treatment plan included chiropractic adjustment, lumbar traction, and electrical stimulation. The injured worker responded "favorably" to treatment and was progressing as expected. According to a chiropractic treatment note dated 11-30-2015, the injured worker reported ongoing pain. Prolonged walking was also painful. He reported that he was going to the mall over the weekend and took a few minutes to walk with increased pain noted. Pain was constant. Treatments seemed to be "helpful momentarily temporarily." There were some restrictions noted at the thoracolumbar region at T9, T11, L5, and right sacroiliac joints. An authorization request dated 12-01-2015 was submitted for review. The requested services included chiropractic treatment, lumbar traction, electrical stimulation and TENS unit. On 12-10-2015, Utilization Review non-certified the request for TENS unit, lumbar traction and electrical stim.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit:** Upheld

**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:** CA-MTUS states, "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy." MTUS further states, "Not recommended as an isolated intervention" and details the criteria for selection: Pain is ineffectively controlled due to diminished effectiveness of medications, or pain is ineffectively controlled with medications due to side effects, or history of substance abuse, or significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment, or unresponsive to conservative measures (e.g. repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits." The ODG states: Acute: Not recommended based on published literature and a consensus of current guidelines. No proven efficacy has been shown for the treatment of acute low back symptoms. (Herman, 1994) (Bigos, 1999) (van Tulder, 2006) Chronic: Not generally recommended as there is strong evidence that TENS is not more effective than placebo or sham. (Airaksinen, 2006) There is minimal data on how efficacy is affected by type of application, site of application, treatment duration, and optimal frequency/intensity. (Brousseau, 2002) There are sparse randomized controlled trials that have investigated TENS for low back pain. The treating physician does not document that poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/ treatments unresponsiveness to conservative measures or a previous trial of therapy. As such, the current request for a TENS unit is deemed not medically necessary.

**Lumbar traction:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter: Traction.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, lumbar and thoracic; Traction.

**Decision rationale:** The ODG states regarding lumbar traction: "Not recommended using powered traction devices, but home-based patient controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been

proved effective for lasting relief in the treatment of low back pain. Traction is the use of force that separates the joint surfaces and elongates the surrounding soft tissues. (Beurskens, 1997) (Tulder, 2002) (van der Heijden, 1995) (van Tulder, 2000) (Borman, 2003) (Assendelft-Cochrane, 2004) (Harte, 2003) (Clarke, 2006) (Clarke, 2007) (Chou, 2007) The evidence suggests that any form of traction may not be effective. Neither continuous nor intermittent traction by itself was more effective in improving pain, disability or work absence than placebo, sham or other treatments for patients with a mixed duration of LBP, with or without sciatica." The available medical record does not define this request as being for gravity traction, the record also does not provide a description of the nature of the program this is to be an adjunct to. As such the request for Lumbar traction is deemed not medically necessary.

**Electrical Stim:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Thoracic and lumbar; electrical stimulators.

**Decision rationale:** The CA-MTUS states: See specific individual treatment topics for treatment guidelines regarding the exact type of electrical stimulation treatment. The following are the choices: "See Transcutaneous electrotherapy for TENS, chronic pain (transcutaneous electrical nerve stimulation), TENS, post operative pain (transcutaneous electrical nerve stimulation) Electroceutical therapy (bioelectric nerve block), Galvanic stimulation Neuromuscular electrical stimulation (NMES), H-wave stimulation (HWT), Interferential current stimulation (ICS), Microcurrent electrical stimulation (MENS devices), RS-4i sequential stimulator Sympathetic therapy Dynatron STS. Percutaneous electrical nerve stimulation (PENS), Percutaneous neuromodulation therapy (PNT), Spinal cord stimulation. The ODG similarly states: See more specific therapy. The following are choices: Bone-growth stimulators (BGS), Hyperstimulation analgesia, H-wave stimulation (devices), Interferential therapy, Localized high-intensity neuro-stimulation, Microcurrent electrical stimulation (MENS devices), Neuroreflexotherapy, Neuromuscular electrical stimulation (NMES), Percutaneous electrical nerve stimulation (PENS), Percutaneous neuromodulation therapy (PNT), Spinal cord stimulation, Sympathetic therapy, and Transcutaneous electrical neurostimulation (TENS)." The available medical record fails to specify which precise modality is being requested, a recommendation cannot be made without this information. Further, the record notes prior use of some form of e-stim but provides no detail as to benefit. As such, the request for Electrical Stim is deemed not medically necessary.