

<b>Case Number:</b>	CM14-0114434		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	12/08/2010
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	07/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 61-year-old male who reported an injury on 12/08/2010. The mechanism of injury was noted to be an electric shock. The electric shock reportedly hurled him backwards approximately 3 to 4 feet into a wall and he struck and back of his head against a door jam and his back against a wall. He is diagnosed with lumbar sprain/strain and left lower extremity radiculopathy. His past treatments were noted to include activity modification and epidural steroid injection. On 05/29/2014, the injured worker presented with complaints of low back pain and severe spasm with radiating symptoms to the left lower extremity. The physical examination revealed a markedly antalgic gait favoring the left lower extremity, spasm of the bilateral paraspinals, tenderness to palpation of the lower lumbar facet joints, positive Fabere's test, and a positive straight leg raise on the left side. His medications were noted to include naproxen and Norco. The treatment plan included medication refills and followup in 4 to 6 weeks. A medical necessity addendum for back bracing and lumbar supports was signed on 06/24/2014. However, this document did not specify the type of brace requested or the rationale for this treatment. There was also no rationale or documentation addressing the requested TENS unit. The request for authorization form was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** According to the California MTUS/ACOEM Guidelines, use of lumbar supports is not recommended beyond the acute phase of symptom relief. As the injured worker was noted to have been injured on 12/08/2010, he has exceeded the acute phase of symptom relief and use of a lumbar brace is not recommended. Additionally, there was no documentation regarding the rationale for the requested brace. As the guidelines do not support the use of a lumbar brace for chronic pain, the request is not supported. As such, the request is non-certified.

**TENS unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** According to the California MTUS/ACOEM Guidelines use of a TENS unit is not recommended as an isolated intervention, but a 1 month home based trial of TENS may be supported when used as an adjunct to a program of evidence based functional restoration. The clinical information submitted for review failed to provide any details regarding the requested TENS unit. The injured worker was not shown to be participating or have a plan for participating in a therapeutic exercise program. Additionally, there was no documentation indicating that he had previously undergone a 1 month home based TENS trial which is recommended prior to the purchase of a TENS unit. For the reasons noted above, the request is not medically necessary.