MAXIMUS Federal Services

Case Number:	CM14-0160794		
Date Assigned:	10/06/2014	Date of Injury:	02/11/2014
Decision Date:	12/19/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/30/2014

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 Family Medicine and is licensed to practice in California. 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:

This is a 40 year old patient who sustained a work related injury on 02/11/2014 The exact mechanism of injury was not specified in the records provided. The current diagnosis includes lumbar disc disorder per the doctor's note dated 7/24/14; patient has complaints of constant burning pain in the low back with radiation of the pain into the lower extremities with pain at 8/10. Physical examination revealed paravertebral muscle tenderness and spasm, positive seated nerve root test, guarded and restricted standing flexion and extension, tingling and numbness in the posterior leg and lateral foot, weakness in the plantar flexors and in the S 1 innervated muscles graded 4/5 and reflexes were asymmetrical. Per the doctor's note dated 5/9/14 patient had complaints of low back pain with stiffness leg. Physical examination revealed limited ROM, positive Patrick Faber test and Kemps test and paravertebral muscle spasm The current medication lists include Naproxen, Omeprazole, Ondansetron, Cyclobenzaprine, Voltaren and Menthoderm Diagnostic imaging reports were not specified in the records provided. Any surgical or procedure note related to this injury were not specified in the records provided. Other therapy done for this injury was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Purchase of Pro-Stim 5.0 plus 3 Months Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS).

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

Decision rationale: According the cited guidelines, electrical stimulation (TENS), is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief. A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)."According the cited guidelines, Criteria for the use of TENS is "- There is evidence that other appropriate pain modalities have been tried (including medication) and failed and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted."Any evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. A detailed response to previous conservative therapy was not specified in the records provided. Previous conservative therapy notes were not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the electrical stimulation unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use electrical stimulation as an adjunct to a program of evidence-based functional restoration. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse was not specified in the records provided. The medical necessity of the electrical stimulation unit is not fully established and therefore the need for the electrical stimulation unit supplies is also not established. The request for DME: Purchase of Pro-Stim 5.0 plus 3 Months Supplies is not fully established for this patient. The request is not medically necessary.

DME: Purchase of Kronos Lumbar Spine Pneumatic 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 (ODG), Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG Chapter:Low Back (updated 11/21/14) Lumbar supports

Decision rationale: Per the ACOEM guidelines cited below "There is no evidence for the effectiveness of lumbar supports in preventing back pain in industry." In addition per the ODG cited below regarding lumbar supports/brace, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. Treatment: 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). Under study for post-operative use; see Back brace, post operative (fusion)." The details of PT or other types of therapy done since the date of injury were not specified in the records provided. Response to prior conservative therapy was not specified in the records provided. Prior conservative therapy notes were not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. There is no evidence of instability, spondylolisthesis, lumbar fracture or recent lumbar surgery. The rationale for the use of a brace with the additional feature of a pneumatic device is not specified in the records provided. The medical necessity, of DME: Purchase of Kronos Lumbar Spine Pneumatic Brace is not fully established. The request is not medically necessary.