

<b>Case Number:</b>	CM14-0038568		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	06/28/2011
<b>Decision Date:</b>	02/27/2015	<b>UR Denial Date:</b>	03/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2014

### 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. 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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

### 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 man sustained an industrial injury on 6/28/2011 when he was lifting an iron bar with a co-worker and the co-worker dropped it. The worker fell forward, smashed his fingers, was unable to move his feet, and felt a pulling sensation in his back. Current diagnoses include lumbar strain/sprain, lumbar herniated disc at L3-L4, and a history of cervical spine injury with residuals. Treatment has included oral medications, a cane for ambulation, home exercise program, and physical therapy. Physicain notes dated 1/29/2014 shows complaints of constant pain in the low back, rated 7/10, that travels to his bilateral legs. There is also mention of anxiety and depression due to the pain and stress. The physical examination shows cervical spine tightness, spasm, and muscle guarding at the trapezius, sternoicleidomastoid, and strap muscles bilaterally. There is also tenderness of the spinal proccesses of the cervical vertebrae bilaterally and decreased sensation on the left side. The lumbar spine shows a significant decrease in range of motion per measurements, decreased lordosis and positive straight leg raise test at 70 degrees bilaterally. Lumbar spine sensation is decreased bilaterally . Generalized weakness is noted throughout the lower extremities including the feet, knees, and hips bilaterally. An MRI from 11/7/2012 was reviewed and showed L3-L4 1.2 mm disc protrusion and L4-L5 2.3 mm disc protrusion. Recommendations included an epidural steroid injection at L3-L4, L4-L5, and L5-S1, EMG/NCV of the bilateral lower extremities, an updated MRI of the lumbar spine, LSO brace for support and relief, TENS unit for home use, self-limited and self-modified home exercise program, and oral medications as prescribed. The worker is noted to be temporarily totally disabled. On 3/19/2014, Utilization Review evaluated prescriptions for a neurostimulator TENS

EMS with supplies for home based monthly rental and LSO back support. The UR physician noted that it was unclear whether the worker had a one month home trial and there was no documentation of the results of such trial. Further, there is a lack of information to support the use of a back support to provide functional improvement in this setting. The requests were denied and subsequently appealed to Independent Medical Review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Lumbar Sacral Orthosis (LSO) back support for purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 298-301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Low Back ( Lumbar and Thoracic), Lumbar Support

**Decision rationale:** ACOEM states, Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states, Not recommended for prevention. Recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (van Duijvenbode, 2008). ODG states for use as a treatment. 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).The patient is beyond the acute phase of treatment and the treating physician has provided no documentation of spondylolisthesis or documented instability. As such the request for Lumbar Sacral Orthosis (LSO) back support for purchase is not medically necessary.

**Neurostimulator Transcutaneous Electrical Nerve Stimulation (TENS) Electrical Muscle Stimulator (EMS) with supplies rental month home based:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 03/07/14)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision based on Non-MTUS Citation Pain, TENS chronic pain (transcutaneous electrical nerve stimulation)

**Decision rationale:** MTUS states regarding TENS unit, "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." For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention; Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program; Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings; Ankle and foot: Not recommended; Elbow: Not recommended; Forearm, Wrist and Hand: Not recommended; Shoulder: Recommended for post-stroke rehabilitation. Medical records do indicate conditions of the low back, but none of the other indicated conditions (knee, neck, ankle, elbow, or shoulders that meet guidelines. Of note, medical records do not indicate knee osteoarthritis). ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration. (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing 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; rental would be preferred over purchase during this trial. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage. (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The medical records do not satisfy the several criteria for selection specifically, lack of documented 1-month trial and lack of documented short-long term treatment goals with TENS unit. The UR and IMR state this is a request for Neurostimulator Transcutaneous Electrical Nerve Stimulation (TENS) Electrical Muscle Stimulator (EMS) with supplies rental month home based, however the order (3/12/14) and physician notes request a TENS unit. As such, the request for Neurostimulator Transcutaneous Electrical Nerve Stimulation (TENS) Electrical Muscle Stimulator (EMS) with supplies rental month home based is not medically necessary.