

<b>Case Number:</b>	CM15-0122322		
<b>Date Assigned:</b>	07/06/2015	<b>Date of Injury:</b>	07/18/2006
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 54 year old male, who sustained an industrial injury on 07/18/2006. The injured worker reported that he was pinned between an electric conveyor and boxes. The injured worker was diagnosed as having right lumbar radicular symptoms status post surgery with fusion with post-operative complication of the left sacroiliac with hypesthesia to the left lateral foot and sole of the foot, secondary depression due to above noted diagnosis with psychiatric hospitalization, and insomnia. Treatment and diagnostic studies to date has included medication regimen, use of a transcutaneous electrical nerve stimulation unit, and use of ice. In a progress note dated 03/20/2015 the treating physician reports complaints of low back pain with occasional radiation to the right leg, depression, gastrointestinal upset that has improved with medication, and difficulty sleeping secondary to pain that has improved with medication. Examination reveals decreased sensation to the right big toe and the paralumbar region, slow gait secondary to back pain, depressed mood, tenderness to the lateral thoracic and lumbar regions with spasm noted, positive straight leg test on the right, paralumbar muscle spasm, and decreased range of motion to the lumbar spine. The treating physician requested supplies for a transcutaneous electrical nerve stimulation unit with the treating physician noting that the transcutaneous electrical nerve stimulation unit is extremely helpful with the injured worker's pain, but has not received supplies for his transcutaneous electrical nerve stimulation unit preventing use of this equipment. The treating physician also requested a back brace with the treating physician noting that use of this equipment could assist with keeping the injured worker's pain level under control and provide support for the strain.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Back Brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Lumbar Supports.

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

**Decision rationale:** According to MTUS guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A lumbar corset is recommended for prevention and not for treatment. Therefore, the request for back Brace is not medically necessary.

**TENS Supplies Lumbar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** According to MUTUS guidelines, TENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. According to the medical reports submitted for review, the patient has experienced significant benefit with the TENS unit. However, there is no evidence that a functional restoration program is planned for this patient. Therefore, the request for TENS supplies is not medically necessary.