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| <b>Case Number:</b>   | CM15-0079476 |                              |            |
| <b>Date Assigned:</b> | 05/01/2015   | <b>Date of Injury:</b>       | 01/08/2013 |
| <b>Decision Date:</b> | 06/01/2015   | <b>UR Denial Date:</b>       | 04/08/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/24/2015 |

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 27 year old male, who sustained an industrial injury on 01/08/2013. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having significant residuals after prior spine surgery, depression/anxiety, insomnia, poor memory, and possible cauda equina syndrome. Treatment to date has included use of a cane, medication regimen, status post spinal surgery, and psychiatric therapy. In a progress note dated 03/25/2015 the treating physician reports complaints of constant low back pain with radiating pain to the bilateral lower extremities along with sharp, severe pain to the mid spine and a loose right hip with weakness. The back pain is rated a nine out of ten. The medical records provided did not contain the specific reasons for the requested treatments of a more robust lumbar brace, the purchase of a transcutaneous electrical nerve stimulation unit, and range of motion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**More Robust lumbar brace:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 12: Low Back Disorders, p138- 139.

**Decision rationale:** The claimant is more than 2 years status post work-related injury and continues to be treated for back and radiating leg pain after spinal surgery. When seen, pain was rated at 9/10. The claimant was ambulating with a cane. There was lumbar paraspinal muscle tenderness with positive straight leg raising and decreased lower extremity sensation and strength. Guidelines recommend against the use of a lumbar support other than for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. In this case, there is no spinal instability or other condition that would suggest the need for a lumbar orthosis and the claimant has not undergone surgery. Lumbar supports have not been shown to have lasting benefit beyond the acute phase of symptom relief and prolonged use of a support may discourage recommended exercise and activity with possible weakening of the spinal muscles and a potential worsening of the spinal condition. The requested lumbar support was therefore not medically necessary.

**TENS Unit Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation Page(s): 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Neuromuscular electrical stimulation (NMES devices), p 121 (2) Transcutaneous electrotherapy, p 114 Page(s): 114, 121.

**Decision rationale:** The claimant is more than 2 years status post work-related injury and continues to be treated for back and radiating leg pain after spinal surgery. When seen, pain was rated at 9/10. The claimant was ambulating with a cane. There was lumbar paraspinal muscle tenderness with positive straight leg raising and decreased lower extremity sensation and strength. In terms of TENS, a one-month home-based trial may be considered as a noninvasive conservative option. Criteria for the continued use of TENS include documentation of a one-month trial period of the TENS unit including how often the unit was used, as well as outcomes in terms of pain relief. In this case, there is no documented home-based trial of TENS. Therefore purchasing a TENS unit was not medically necessary.

**Range of Motion:** 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 Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic), Range of motion (ROM).

**Decision rationale:** The claimant is more than 2 years status post work-related injury and continues to be treated for back and radiating leg pain after spinal surgery. When seen, pain was rated at 9/10. The claimant was ambulating with a cane. There was lumbar paraspinal muscle tenderness with positive straight leg raising and decreased lower extremity sensation and strength. Guidelines address range of motion, which should be a part of a routine musculo-skeletal evaluation. In this case, the claimant's primary treating provider would be expected to be able to measure range of motion. Therefore the request was not medically necessary.