

<b>Case Number:</b>	CM15-0097108		
<b>Date Assigned:</b>	05/27/2015	<b>Date of Injury:</b>	02/25/2015
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 45 year old male, who sustained an industrial injury on 8/1/2013 and from 5/15/2012 to 2/25/2015. Diagnoses include neck sprain/strain, tendinosis, and rotator cuff partial tear left shoulder and right shoulder tendinosis impingement. Treatment to date has included diagnostics, medications and activity modification. Magnetic resonance imaging (MRI) of the right shoulder dated 3/31/2015 showed tendinosis and edema of the rotator cuff, minimal impingement syndrome and fluid is seen in the glenohumeral joint space and sub deltoid space. Per the Primary Treating Physician's Progress Report dated 4/14/2015, the injured worker reported bilateral shoulder pain rated as 8/10 and neck pain rated as 7/10. Physical examination of the shoulder revealed decreased external/internal rotation and neck with decreased extension. The plan of care included orthopedic consult, topical creams, urinalysis and DNA testing. Authorization was requested for inferential (IF) unit purchase, LSO back support, electrodes, batteries, set up and delivery for purchase of the low back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential Unit Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): Chp 3 pg 48-9; Chp 9 pg 203; Chp 12 pg 300, 308, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-120.

**Decision rationale:** IF (Interferential Stimulator) units are transcutaneous electrical nerve stimulation (TENS) units that use electric current produced by a device placed on the skin to stimulate the underlying nerves and which can result in lowering acute or chronic pain. It differs from other TENS units in that it modulates a TENS pulse at a higher wavelength. This presumably reduces the capacitance of skin and allows deeper penetration of the electrical currents into the skin. However, there is a lot of conflicting evidence for use of TENS and the MTUS specifically notes that IF therapy is not recommended as an isolated therapy. The MTUS does recommend TENS therapy during the first 30 days of the acute post-surgical period although it notes that its effectiveness for orthopedic surgical procedures is not well supported by the literature. This request for use on an IF unit in this patient is not during the immediate post-surgical period although it is in conjunction with other therapies (medication, physical therapy, acupuncture and chiropractic therapy). This meets the criteria required for a trial of IF therapy but not for purchase of said unit. Thus medical necessity for purchase of an IF unit has not been established and therefore is not medically necessary.

**Lumbosacral orthotic back support:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307-8. Decision based on Non-MTUS Citation 1) North American Spine Society (NASS). Diagnosis and treatment of degenerative lumbar spinal stenosis. Burr Ridge (IL): North American Spine Society (NASS); 2011. 104 p. [542 references] 2) Canadian Institute of Health Economics: Toward Optimized Practice. Guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2011. 37 p. [39 references].

**Decision rationale:** A Lumbar-Sacral Orthosis (LSO) Back Brace is a device designed to limit the motion of the spine. It is used in cases of vertebral fracture or in post-operative fusions, as well as a preventative measure against some progressive conditions or for work environments that have a propensity for low back injuries. The patient has none of these indications. The ACOEM guideline as well as other guidelines do not recommend use of a back brace or corset for treating low back pain as its use is not supported by research-based evidence. When back braces are used any benefits from its use goes away as soon as the brace is removed. Although this patient does experience back pain there is no mention of significant impairment in most of his activities of daily living nor a diagnosis that would support use of a LSO brace. Considering

the known science and the patient's documented impairments there is no indication for use of a back brace in treating this patient at this time. Medical necessity has not been established.

**Electrodes and batter:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): Chp 3 pg 48-9; Chp 9 pg 203; Chp 12 pg 300, 308, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-20.

**Decision rationale:** IF (Interferential Stimulator) units are transcutaneous electrical nerve stimulation (TENS) units that use electric current produced by a device placed on the skin to stimulate the underlying nerves and which can result in lowering acute or chronic pain. It differs from other TENS units in that it modulates a TENS pulse at a higher wavelength. This presumably reduces the capacitance of skin and allows deeper penetration of the electrical currents into the skin. However, there is a lot of conflicting evidence for use of TENS and the MTUS specifically notes that IF therapy is not recommended as an isolated therapy. The MTUS does recommend TENS therapy during the first 30 days of the acute post-surgical period although it notes that its effectiveness for orthopedic surgical procedures is not well supported by the literature. This request for use on an IF unit in this patient is not during the immediate post-surgical period although it is in conjunction with other therapies (medication, physical therapy, acupuncture and chiropractic therapy). This meets the criteria required for a trial of IF therapy but not for purchase of said unit. Since a trial of the IF unit has met the criteria for its use, the use of electrodes and batteries for a trial use should be provided. Thus medical necessity for purchase of electrodes and batteries to support a trial of an IF unit has been established.

**Set Up and delivery:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 3 Initial Approaches to Treatment, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Chp 3 pg 48-9; Chp 9 pg 203; Chp 12 pg 300, 308, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-20.

**Decision rationale:** IF (Interferential Stimulator) units are transcutaneous electrical nerve stimulation (TENS) units that use electric current produced by a device placed on the skin to stimulate the underlying nerves and which can result in lowering acute or chronic pain. It differs from other TENS units in that it modulates a TENS pulse at a higher wavelength. This presumably reduces the capacitance of skin and allows deeper penetration of the electrical currents into the skin. However, there is a lot of conflicting evidence for use of TENS and the MTUS specifically notes that IF therapy is not recommended as an isolated therapy. The MTUS

does recommend TENS therapy during the first 30 days of the acute post-surgical period although it notes that its effectiveness for orthopedic surgical procedures is not well supported by the literature. This request for use on an IF unit in this patient is not during the immediate post-surgical period although it is in conjunction with other therapies (medication, physical therapy, acupuncture and chiropractic therapy). This meets the criteria required for a trial of IF therapy but not for purchase of said unit. Since a trial of the IF unit has met the criteria for its use, set up and delivery for a trial use should be provided. Thus medical necessity for set up and delivery to support a trial of an IF unit has been established.