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| <b>Case Number:</b>   | CM14-0193025 |                              |            |
| <b>Date Assigned:</b> | 11/26/2014   | <b>Date of Injury:</b>       | 11/28/2013 |
| <b>Decision Date:</b> | 04/06/2015   | <b>UR Denial Date:</b>       | 10/27/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/18/2014 |

### 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: California, Washington

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 55-year-old female who reported an injury on 11/28/2013. The mechanism of injury was not stated. The current diagnoses include lumbar radiculopathy and lumbar spondylosis. The injured worker presented on 09/23/2014 for a followup evaluation. The injured worker reported low back pain with radiating symptoms into the right lower extremity, as well as stiffness and muscle spasm. Examination of the lumbar spine revealed 80 degree flexion, tenderness at the L4-5 level, positive straight leg raise and positive faber test. Examination of the knee revealed 90 degree flexion. The injured worker was utilizing a right knee brace. There was diminished sensation in the right thigh in the lateral femoral cutaneous nerve. Recommendations included a TENS unit for the lumbar spine with supplies, as well as a right knee brace, a back brace, a seated walker and acupuncture treatment once per week for 4 weeks. A Request for Authorization form was submitted on 10/13/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right knee brace for purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Knee Brace.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a brace can be used for patellar instability, ACL tear or MCL instability. In this case, there was no evidence of significant instability upon examination. There was no documentation of a significant functional deficit. It was also noted that the injured worker was utilizing a knee brace. The medical necessity for a second device has not been established in this case. As such, the request is not medically appropriate.

**Back brace for purchase:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. There was no evidence of instability upon examination. There was no documentation of a significant functional limitation. The medical necessity has not been established. As such, the request is not medically appropriate.

**TENS unit and supplies for purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** California MTUS Guidelines do not recommend transcutaneous electrotherapy as a primary treatment modality, but a 1 month home based trial may be considered as a noninvasive conservative option. In this case, there was no evidence of a failure of other appropriate pain modalities including medication. Guidelines recommend a 1 month trial prior to a unit purchase. There was no documentation of a successful 1 month trial. As such, the request is not medically appropriate.