

<b>Case Number:</b>	CM15-0005717		
<b>Date Assigned:</b>	01/20/2015	<b>Date of Injury:</b>	03/29/2008
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/12/2015

### 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: Physical Medicine & Rehabilitation

### 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 sustained an industrial injury on 3/29/2008. She has reported left knee pain and is status post left total knee replacement completed January 2010 which was revised November 2010. The diagnoses have included left knee pain, degenerative joint disease and status post knee replacement and revision. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Vicodin, topical analgesic, physical therapy, and a knee brace. Currently, the IW complains of persistent left knee pain improved with medication and now complaining of back pain resulting from altered gait due to the left knee abnormality. Physical examination documented on July 18, 2014, the left knee was able to extend no more than 160 degrees and able to flex approximately 120 degrees. Strength of right leg 5/5 and left was 3-4/5. Reduced Range of Motion (ROM) of the lumbar spine was observed. On 1/6/2015 Utilization Review non-certified a Transcutaneous Electrical Nerve Stimulation (TENS) unit and supplies, Lumbar-Sacral Orthosis (LSO) back brace for purchase, noting insufficient documentation to support medical necessity. The MTUS Guidelines were cited. On 1/12/2015, the injured worker submitted an application for IMR for review of Transcutaneous Electrical Nerve Stimulation (TENS) unit and supplies, Lumbar-Sacral Orthosis(LSO) back brace for purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro TENS unit and supplies x 30 days:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

**Decision rationale:** This patient presents with left knee pain and is status post left total knee replacement completed January 2010. The patient is now complaining of back pain resulting from altered gait due to the left knee abnormality. The current request is for Retro Tens Unit And Supplies X30days. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, and multiple scoliosis. When a TENS unit is indicated, a 30-home trial is recommended and with documentation of functional improvement, additional usage may be indicated. In this case, the patient does not meet any of the indications for a TENS unit as outlined in MTUS. This request is not medically necessary.

**Retro LSO back brace for purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Back Braces/Lumbar Supports

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

**Decision rationale:** This patient presents with left knee pain and is status post left total knee replacement completed January 2010. The patient is no complaining of back pain resulting from altered gait due to the left knee abnormality. The current request is for Retro Lso Back Brace For Purchase. ACOEM Guidelines page 301 on lumbar bracing state, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under its low back chapter, Lumbar Supports, states, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment, ODG further states, "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." In this case, the patient does not present with fracture, documented instability, or spondylolisthesis to warrant lumbar bracing. For non-specific low back pain, there is very low quality evidence. The requested back brace is not medically necessary.

