

<b>Case Number:</b>	CM15-0052151		
<b>Date Assigned:</b>	03/25/2015	<b>Date of Injury:</b>	06/09/2002
<b>Decision Date:</b>	05/07/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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: New York, Pennsylvania, Washington

Certification(s)/Specialty: Internal Medicine, Geriatric 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 67 year old female, who sustained an industrial injury on 6/9/02. The injured worker was diagnosed as having internal derangement of the knee status post meniscectomy, impingement syndrome of shoulder on the right status post decompression, discogenic lumbar condition with facet inflammation status post injection and chronic pain syndrome. Treatment to date has included knee brace, TENS unit, oral medications, physical therapy and activity restrictions. Currently, the injured worker complains of persistent neck and low back pain, right shoulder and right knee pain. Upon physical exam, tenderness is noted across the cervical paraspinal muscles and trapezius bilaterally as well as along the lumbar paraspinal muscles worse on the right. The treatment plan included refill of medications, replacement of knee brace, authorization for low back brace, TENs unit and activity restrictions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF or muscle stimulator:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 113-117.

**Decision rationale:** Per the guidelines, a TENS or inferential unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters, which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. In this injured worker, other treatment modalities are not documented to have been trialed and not successful. Additionally, it is not being used as an adjunct to a program of evidence based functional restoration. There is no indication of spasticity, phantom limb pain, post-herpetic neuralgia or multiple sclerosis which the TENS unit may be appropriate for. The medical necessity for a TENS unit is not substantiated and is not medically necessary.

**Lumbar back support and back insert:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 12 Low Back Complaints Page(s): 9, 301.

**Decision rationale:** This injured worker has complaints of chronic back pain. Per the ACOEM, the use of back belts as lumbar support should be avoided as they have shown little or no benefit, thereby providing only a false sense of security. Additionally, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. It is not clear the rationale from the records for a lumbar support brace at this point in the treatment. The records do not substantiate the medical necessity for a Lumbar back support and back insert. Therefore, the requested medical treatment is not medically necessary.

**Defiance brace molded plastic for the right lower and upper knee:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340-359.

**Decision rationale:** Per the ACOEM, a knee brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability although its benefits may be more emotional than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the

average patient, using a brace is usually unnecessary. In this injured worker with chronic knee pain, the records do not substantiate patellar or MCL instability or ACL tear. The medical necessity of a brace for the right knee is not substantiated and is not medically necessary.