

<b>Case Number:</b>	CM14-0006473		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	05/04/2007
<b>Decision Date:</b>	06/23/2014	<b>UR Denial Date:</b>	01/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2014

### 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. The expert reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in Mississippi. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 66-year-old female who sustained an injury to her low back on May 4, 2007. Mechanism of injury was not documented. The injured worker was referred for a pain management consultation. The injured complained of low back pain, which she rated at 8/10 on the Visual Analogue Scale (VAS) which is described as constant, radiating down to the bilateral legs and down to the ankle. The injured worker stated it feels like a pulling sensation up to her back. The record indicates the injured's pain gets worse with sitting/standing. The pain is reported as radiating up the neck with associated stiffness. The injured worker can hardly move her neck from side to side. The diagnosis is lumbar disc disease, radiculopathy and facet syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **BILATERAL L5-S1 AND BILATERAL S1 TRANSFORAMINAL EPIDURAL STEROID INJECTION (ESI) X 2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

**Decision rationale:** The request for two bilateral L5-S1 transforaminal epidural steroid injections is not medically necessary. The previous request was denied on the basis that there was no imaging study of the lumbar spine provided in the medical records presented to be reviewed. The California Medical Treatment Utilization Schedule (CAMTUS) states that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Given the clinical documentation submitted for review, medical necessity of the request for bilateral L5-S1 and bilateral S1 transforaminal epidural steroid injection times two has not been established. The request is not medically necessary and appropriate.

**EMS UNIT (30 DAY TRIAL FOR HOME USE):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS) Unit Page(s): 1.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tens, Chronic Pain (Transcutaneous Electrical Nerve Stimulation).

**Decision rationale:** The request for EMS unit (30 day trial for home use) is not medically necessary. The California Medical Treatment Utilization Schedule (CAMTUS) states that while Transcutaneous Electrical Nerve Stimulation (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. Given the clinical documentation submitted for review, medical necessity of the request for EMS unit (30 day trial for home use) has not been established. The request is not medically necessary and appropriate.

**LEFT C5-C7 SELECTIVE EPIDURAL CAUTERIZATION UNDER FLUOROSCOPIC GUIDANCE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Facet Joint Radiofrequency Neurotomy

**Decision rationale:** The request for left C5-C7 selective epidural cauterization under fluoroscopic guidance is not medically necessary. The Official Disability Guidelines (ODG) states treatment with this modality is under study. Conflicting evidence, which is primarily observational, is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Given the clinical documentation submitted for review, medical necessity of the request for left C5-C7 selective epidural cauterization under fluoroscopic guidance has not been established. The request is not medically necessary and appropriate.

## **LUMBAR-SACRAL ORTHOSIS (LSO) BRACE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines-Treatment for Workers' Compensation (TWC), Lumbar & Thoracic (Acute & Chronic)

**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 Chapter, Lumbar Supports

**Decision rationale:** The request for lumbar-sacral orthosis (LSO) brace is not medically necessary. The Official Disability Guidelines (ODG) states there is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective, and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. Given the clinical documentation submitted for review, medical necessity of the request for lumbar-sacral orthosis (LSO) brace has not been established. The request is not medically necessary and appropriate.

## **URINE TOXICOLOGY SCREENING: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Urine Drug Testing (UDT).

**Decision rationale:** The request for urine toxicology screening is not medically necessary. The Official Disability Guidelines (ODG) states this modality is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances; however, there was no information provided that indicates that the injured worker is at risk for medication abuse. There was no indication of any aberrant behavior that would warrant the need for routine drug screening. Given the clinical documentation submitted for review, medical necessity of the request for urine toxicology screening has not been established. The request is not medically necessary and appropriate.