

<b>Case Number:</b>	CM14-0016454		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	11/17/1999
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 patient is a 43 year old female who was injured on 11/17/1999 while she was coming out of a room backwards while pulling a client in a wheelchair when another client behind her pulled her down by her hair, hurting her neck and back. Prior treatment history has included in 2002 the patient had 3 sets of epidural injections of the low back with positive response. Medications include Voltaren and Norco. Diagnostic studies reviewed include x-rays of the lumbar spine dated 09/27/2013 revealing narrowed disc space between L5-S1 and a pain management stimulator at the right gluteal region. A CT scan of the lumbar spine dated 09/27/2013 revealed L5-S1 4 mm posterior disc protrusion which is contained within the ventral epidural fat. AT L4-5 a 2.5 mm posterior disc protrusion was noted. Progress note dated 12/18/2013 documented the patient to have complaints of severe pain in the low back with radiation down to the right buttock all the way down to the right leg from the low back. Now, [REDACTED], she has severe flare-up of her low back pain with radiation down the right leg and she wants to have epidural steroid injections again. Objective findings on examination of the thoracic/lumbar spine revealed there was muscle spasm of the lumbar spine. Right-sided erector spinalis trigger points were positive. There was tenderness on the right of the lumbar spine paravertebral. Seated SLR was positive on the right. There was general muscle weakness secondary to pain on the right side of the low back. Flexion, extension and right lateral flexion maneuvers demonstrated decreased strength of 4/5 and a loss of range of motion. Flexion and extension caused moderate pain and right lateral flexion caused mild pain. There was good Dorsiflexion and plantar flexion power noted. Girth measurements are as follows: Right Left Thighs 42.5 41.2 Calves: 34.7 33 There was decreased motor strength to the right-sided C6 and C7 nerve root dermatomes. Diagnoses: Lumbar neuritis/radiculitis. Discussion: The patient has tried various therapy modalities as well as various medications including anti-inflammatory medications and analgesics, but the pain is

persisting. At this time proper course of action is to provide epidural steroid injections. The hope is by performing these outpatient injections; we can avoid surgery for this patient's low back. Treatment Plan: 1. Requesting authorization from the insurance company for 2 sets of epidural steroid injections of the lumbar spine at L4-S1. 2. Physical therapy 3 times a week for 3 weeks for post-injection rehabilitation. 3. Refill Voltaren and Norco if needed. PR-2 dated 01/15/2014 documents the patient states she continues to have a constant pain. ESI and physical therapy denied 01/13/2014. Medications: Norco bid. Objective findings on exam reveal trigger points in the right lumbar spine. Positive SLR sitting. Her gait is slow. Treatment Plan: Outpatient percutaneous shaver discectomy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **L4-S1 MINIMALLY INVASIVE PERCUTANEOUS SHAVE DISKECTOMY: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 305 AND 307.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back

**Decision rationale:** According to the CA MTUS/ACOEM guidelines, percutaneous discectomy is not recommended because proof of its effectiveness has not been demonstrated. The Official Disability Guidelines also states that percutaneous discectomy is not recommended. Percutaneous lumbar discectomy procedures are rarely performed in the U.S., and no studies have demonstrated the procedure to be as effective as discectomy or microsurgical discectomy. This systematic review found no benefit from minimally invasive percutaneous techniques, and a tendency for more safety in open procedures in lumbar disc surgery. The medical records do not provide a viable rationale to establish the medical necessity of a procedure that is not currently recommended under the evidence-based guidelines due to efficacy not being substantiated. The request for L4-S1 minimally invasive percutaneous shave discectomy is not medically necessary.

#### **LABS: URINALYSIS (UA): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

#### **LABS: PREGNANCY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, PREOPERATIVE TESTING, GENERAL<INSERT TOPIC (FOR EXAMPLE TOTAL KNEE ARTHROPLASTY)>

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**POST-OP PHYSICAL THERAPY 3 TIMES A WEEK FOR 2 WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**MYOFLEX CREAM X 1 TUBE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** According to the CA MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. The medical records do not indicate this patient is unable to tolerate standard treatments, such as oral non-opioid medications. In addition, topical analgesics are generally indicated to treatment of OA and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to support topical NSAIDs for treatment of osteoarthritis of the spine. The patient does not have OA or tendinitis of a small joint. The medical necessity of Myoflex cream is not established.