MAXIMUS Federal Services

| Case Number: | CM14-0024517 | | |
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| Date Assigned: | 06/11/2014 | Date of Injury: | 10/11/2000 |
| Decision Date: | 07/15/2014 | UR Denial Date: | 02/13/2014 |
| Priority: | Standard | Application Received: | 02/26/2014 |

## 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 Occupational Medicine and is licensed to practice in Texas. 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 60 year old male who reported an injury to his mid and low back in October 2000. A clinical note dated 08/05/13 indicated the injured worker complaining of tenderness to palpation in the paravertebral musculature. The injured worker was also identified as guarding. The injured worker had a positive straight leg raise. The injured worker demonstrated 30 degrees of lumbar flexion with 16 degrees of extension and 16 degrees of right sided bending with 18 degrees of left sided bending. The injured worker utilized a Transcutaneous electrical nerve stimulation (TENS) unit and an ongoing home exercise program. The injured worker was undergoing acupuncture treatment. The urine drug screen dated 06/22/13 revealed the injured worker being compliant with prescribed drug regimen. The injured worker was no longer utilizing Norco which was subsequently discontinued. Clinical note dated 10/01/13 indicated the injured worker showing decreased sensation in L5 dermatome. Strength was 4/5 at the left extensor hallucis longus (EHL). Pain was increased upon extension and facet loading. The injured worker continued with range of motion deficits throughout the lumbar spine. A clinical note dated 01/29/14 indicated the injured worker continuing with 4/5 strength at the left EHL and with the knee extensor. Reflexes were decreased at the left knee. The injured worker rated his low back pain as 4/10. The injured worker was also identified as having positive findings confirming Faber test, Yeoman's test, sacroiliac thrust signs, and positive sacroiliac tenderness. The injured worker also reported having positive Kemp sign. The straight leg raise was positive on the left at 40 degrees. The operative report dated 03/21/14 indicated the injured worker undergoing L4-5 and L5-S1 epidural steroid injection on the left.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**LUMBOSACRAL ORTHOSIS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**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 clinical documentation indicates the injured worker complaining of ongoing low back pain. A lumbar support is not medically necessary for prevention. Previous high quality studies demonstrated that lumbar supports are not effective in preventing neck pain and back pain. Additionally, back lumbar supports are not medically necessary for compression fracture and specific treatments for spondylolisthesis, documented instability, or treatment for non-specific low back pain. The clinical documentation indicates the injured worker having complaints consistent with radiculopathy. No information was submitted regarding ongoing instability. Therefore, a lumbar support/orthosis is not medically necessary for this injured worker at this time.

**URINE TOXICOLOGY SCREEN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

**Decision rationale:** The request urine toxicology screen is not medically necessary. The most recent urine drug screen revealed the injured worker having findings consistent with the prescribed drug regimen. No information was submitted regarding any aberrant behaviors or the potential for drug misuse. Given this, the request is not indicated as medically necessary.