

<b>Case Number:</b>	CM14-0195987		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	06/02/2003
<b>Decision Date:</b>	01/16/2015	<b>UR Denial Date:</b>	10/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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:

This 59 year old female sustained injury on 6/2/2003. The mechanism of injury is not clear. She complains of low back pain with numbness and tingling to the right leg. Her pain level was 5-6/10. Her pain is increased by sitting, standing and movement and decreased by lying down. She is having insomnia incontinence, urinary problems and anxiety. Her medication included Flexeril, gabapentin, Anaprox and Ultram. On physical exam her straight leg raise is positive on the right for back and right leg pain. She has decreased range of motion in all planes of the back. She uses a cane for ambulation. In 2011 the injured worker had a L4-5 decompression and fusion with cages and pedicle screws. There is a recommendation for diagnostic hardware block and /or diagnostic L5-S1 medial branch block to assess the pain generator. Her diagnoses include chronic back pain with right sciatic residuals post decompression and fusion; right and left carpal tunnel syndrome, severe spondylosis, major depression, gastroesophageal reflux disease and irritable bowel syndrome. On 7/11/14 laboratory evaluations were done to determine the current level of prescription medication. The results were normal. Her condition is permanent and stationary. There is no clear documentation of activities of daily living, functional capacity or work status. On 10/28/14 Utilization Review non-certified the request for bilateral sacroiliac injection with fluoroscopy based on unclear documentation as to whether conservative care was tried and failed for sacroiliac joints. ODG Guidelines were referenced. L4-5 hardware injection with fluoroscopy was non-certified based on limited evidence of current deficits related to hardware pain or the specific blocks and the injured workers response. ODG were referenced. The back brace was non-certified based on the fact that the injured worker has had prior back surgery and it was expected that a back brace was issued. In addition there is no clear evidence of a recent compression fracture, spondylolisthesis or instability in the lumbar spine. MTUS/ACOEM and ODG were referenced. Transcutaneous electrical nerve stimulator (TENS)

Unit was non-certified based on no prior mention of use of TENS Unit in a clinical setting and no measurable objective and functional improvements. It is unclear as to how this unit is expected to positively impact the injured workers function when efficacy has not been established. Guidelines were referenced.

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

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

#### **Bilateral sacroiliac injection with fluoroscopy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC (Official Disability Guidelines-Treatment Workers Compensation) Hip and Pelvis Procedure

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG Hip and Pelvis Chapter, Sacroiliac Blocks

**Decision rationale:** Regarding the request for sacroiliac joint injections, guidelines recommend sacroiliac blocks as an option if the patient has failed at least 4 to 6 weeks of aggressive conservative therapy. Within the provided documentation, there is no indication that the patient has undergone conservative treatment such as physical therapy. The patient has only been treated with pain medication, which she is not taking consistently according to the urine drug screen tests. In addition, the guideline specifies history and physical examination should suggest a diagnosis with at least three positive exam findings and diagnostic evaluation must first address any other possible pain generators. Within a recent progress note dated on 8/13/2014, there is no documentation of three positive examination findings suggesting a diagnosis of sacroiliac joint dysfunction. The only exam finding was tenderness to palpation paraspinous area and decreased range of motion in all planes. In the absence of clarity regarding these issues, the currently requested sacroiliac joint injections are not medically necessary.

#### **L4-5 hardware injection with fluoroscopy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC (Official Disability Guidelines-Treatment Workers Compensation) Low Back Procedure

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309.

**Decision rationale:** A progress note dating on 4/15/2014, on physical exam, the patient is noted to be heavily dependent on a cane for support. There was a discussion regarding removal of hardware as a treatment option that may reduce her pain, the patient was considering this but wishes to have the diagnostic blocks done first. The guideline states invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. There is no quality study that has shown a diagnostic hardware injection may be a positive

predictor of the success of hardware removal surgery of lumbar spine. Therefore, this request is not medically necessary.

**Back brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation ODG-TWC (Official Disability Guidelines- Treatment Workers Compensation) Low Back Procedure

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 302. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports

**Decision rationale:** Regarding the request for lumbosacral orthosis, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of her treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested Back brace is not medically necessary.

**TENS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117 of 127.

**Decision rationale:** Within the documents provided, there is no clearly stated indication for the use of TENS unit by the ordering provider. There is no documentation that the patient has failed primary treatment modality with pain medications, or whether other conservative treatment such as physical therapy has been attempted. Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) 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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Furthermore, a review of this injured worker's industrial diagnoses failed to reveal any of the indications of multiple sclerosis, spasticity, phantom limb pain, or complex regional pain syndrome which is described by Chronic Pain Medical Treatment Guidelines. By statute, the California Medical Treatment and Utilization Schedule takes precedence over other national guidelines which may have broader indications for TENS unit. The requested TENS unit is not medically necessary.

