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| Case Number: | CM15-0138643 | | |
| Date Assigned: | 07/28/2015 | Date of Injury: | 09/27/2002 |
| Decision Date: | 08/25/2015 | UR Denial Date: | 06/15/2015 |
| Priority: | Standard | Application Received: | 07/17/2015 |

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 65 year old female who sustained an industrial injury on September 27, 2002. She fell on an uneven surface while at work sustaining a twisting injury. She currently complains of thoraco-lumbar spine pain and bilateral knee and bilateral hands pain and has been diagnosed with lumbar degenerative disc disease and osteoarthritis unspecified whether generalized or localized involving the lower leg. Treatment has included medical imaging, medications, surgery, and physical therapy. She had persistent pain to the lower back with radiating pain to the left leg. There was decreased range of motion and loss of strength to the lumbar spine. X-rays of the thoracic spine and lumbar spine show loss of lumbar lordosis. X-rays of the bilateral knees show no increase in osteoarthritis. X-rays of bilateral hands and bilateral wrist showed no increase in osteoarthritis. The treatment plan included a urine toxicology screen, cortisone injection, and follow up. The treatment request included a lumbar epidural steroid injection at L5-S1, walker with seat, and urine toxicology screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46 of 127.

Decision rationale: Regarding the request for Lumbar epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Guidelines recommend that no more than one interlaminar level, or to transforaminal levels, should be injected at one session. Regarding repeat epidural injections, guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Within the documentation available for review, there are no recent subjective complaints or objective examination findings supporting a diagnosis of radiculopathy specifically at the proposed level of treatment. Additionally, there are no imaging or electrodiagnostic studies corroborating the diagnosis of radiculopathy. In the absence of such documentation, the currently requested Lumbar epidural steroid injection is not medically necessary.

Walker with seat: 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) Hip Chapter, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: Regarding the request for the purchase of a walker, Official Disability Guidelines state that assistive devices are recommended to assist with ambulation for patients with arthritis. Within the documentation available for review, it appears the patient was recommended by PT to ambulate with a single point cane. The requesting physician has not identified why the patient would benefit from a walker, as opposed to the single point cane recommended by PT. As such, the currently requested walker is not medically necessary.

Urine toxicology screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79 and 99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter Urine Drug Testing.

Decision rationale: Regarding the request for a urine toxicology test (UDS), CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is no documentation that the patient is currently utilizing drugs of potential abuse. Additionally, there is no documentation that the physician is concerned about the patient misusing or abusing any controlled substances. In light of the above issues, the currently requested urine toxicology test is not medically necessary.