

Case Number:	CM14-0119750		
Date Assigned:	08/06/2014	Date of Injury:	06/01/1990
Decision Date:	09/17/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	07/28/2014

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 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 injured worker is a 59-year-old-female, who sustained an injury at work while another employee pulled and twisted her left upper extremity causing injuries to her neck, left shoulder, lower back and left knee. Since then, she has undergone four back surgeries. Her current complaints are low back pain radiating into both lower extremities, right side worst than the left. On her exam on 4/21/14 she indicated that her pain was at 10/10 and she had midline and paraspinal pain in the mid thoracic spine. She also had pain across the midline and as well as the right side of the low back with myofascial pain. She had severe low back pain with flexion and extension. Neurologically, she had positive straight leg raises bilaterally and she had dysesthesia and hyperesthesia to light touch in the L4 and L5 dermatome on the left side, at the L5 dermatome on the right side. Latest progress report from 6/18/14 indicated that she reported severe low back pain with flexion, extension, and rotation; moreover, she had difficulty arising from a seated position. She continues to use Norco and Soma three to four times per day for pain control. She had a previous epidural steroid injection with 50-70% relief and improved function. MRI examination of the lumbar spine done on 06/02/14 revealed a 5mm disc bulge and foraminal narrowing at L3-4, a 4 mm disc bulge and foraminal narrowing at L2-3, as well as a 2mm disc bulge with foraminal narrowing and facet hypertrophy at L5.-S1. Impressions: failed back surgery syndrome, S/P explanted spinal cord stimulator, and symptoms of thoracic pain with radiating pain to the chest; thoracic radiculopathy along the bilateral T7-T8 area. Request for - Thoracic epidural steroid injections at T7-T8, bilateral L4-L5 and L5-S1transforamina/ epidural steroid injection; LSO Brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thoracic epidural steroid injections at T7-T8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Criteria for the use of Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46.

Decision rationale: As per CA MTUS guidelines, the purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The American Academy of Neurology has concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. As per CA MTUS guidelines, Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The criteria by the guidelines for the use of ESIs for radicular pain management include 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing and 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)". In this case, there is little to no clinical evidence of thoracic radicular pain. There is no imaging evidence of any nerve roots impingement. There is no documentation of trial and failure of conservative management such as physical therapy or home exercise program. Therefore, the request is considered not medically necessary per guidelines.

bilateral L4-L5 and L5-S1 transforaminal epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Criteria for the use of Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46.

Decision rationale: As per CA MTUS guidelines, the purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The American Academy of Neurology has concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. As per CA MTUS guidelines, Epidural steroid injections (ESIs) are

recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The criteria by the guidelines for the use of ESIs for radicular pain management include 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing and 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)". In this case, there is no imaging or electrodiagnostic evidence of any nerve roots impingement. There is no documentation of trial and failure of conservative management such as physical therapy or home exercise program. Therefore, the request is considered not medically necessary per guidelines.

LSO brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical methods-Lumbar supports.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Low back pain, Physical Methods, Lumbar support, 301.

Decision rationale: Per ACOEM guidelines, there is no evidence for the effectiveness of lumbar supports in preventing back pain in industry. Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In this case, there is insufficient evidence to support the need for lumbar brace in this injured worker. At this juncture, the use of lumbar support should be avoided, as these have not been shown to provide any notable benefit, and prolonged use has potential to encourage weakness, stiffness and atrophy of the paraspinal musculature. Based on the CA MTUS/ACOEM and the clinical documentation stated above, the request for a LSO brace is not medically necessary.