

Case Number:	CM15-0187764		
Date Assigned:	09/29/2015	Date of Injury:	03/01/2003
Decision Date:	11/13/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/24/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, 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 53 year old female who sustained an industrial injury March 1, 2003. According to a treating physician's progress notes dated September 2, 2015, the injured worker presented for ongoing evaluation and discussion of pain management. She reports her low back pain, rated 7 out of 10, is slowly coming back and she would like to repeat the epidural steroid injections. The physician documented she had a previous L4-5 and L5-S1 transforaminal epidural steroid injections in March, 2015, providing 95% pain relief for 5 months. Physical findings included; 5"2" and 142 pounds; lumbar spine-flexion 45 degrees with moderate low back pain, extension 10 degrees with facet loading pain, facet tenderness, straight leg raise positive bilaterally at 30 degrees; decreased sensory in bilateral lower extremities particularly in bilateral L4 and L5 dermatomes; gait is mildly antalgic; dysesthesia of lateral legs and feet from hips to toes. Diagnoses are degeneration of lumbar or lumbosacral intervertebral disc; thoracic or lumbosacral neuritis or radiculitis, unspecified; hypertension; sacroiliitis, not elsewhere classified, lumbago; sciatica; chronic pain syndrome; GERD (gastroesophageal reflux disease). Treatment plan included fitting the injured worker with a back brace which provided a 75% reduction in pain and return to office two weeks after injections for ongoing evaluation. At issue, is the request for authorization for a thoracolumbar back brace and bilateral L4-5 and L5-S1 transforaminal epidural injections. An inconsistent urine toxicology report collected March 31, 2015, is present in the medical record. According to utilization review dated September 16, 2015, the request for thoracolumbar back brace is non-certified. The request for (1) bilateral L4-5 and L5-S1 transforaminal epidural steroid injection under fluoroscopic guidance with anesthesia sedation has been modified to certification of (1) bilateral L4-5 and L5-S1

transforaminal epidural steroid injection under fluoroscopic guidance between 09-02-2015 and 11-14-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 thoracolumbar back brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar and Thoracic (Acute and Chronic), Lumbar supports.

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, Lumbar supports.

Decision rationale: Per the ODG with regard to lumbar supports: Not recommended for prevention, recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective, and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (van Duijvenbode, 2008) Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). As there is only very low-quality evidence supporting the use of back braces for the purpose of treatment, therefore, the request is not medically necessary.

Bilateral L4-5 and L5-S1 transforaminal epidural steroid injection under fluoroscopic guidance with anesthesia sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or

electrodiagnostic testing.2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).3) Injections should be performed using fluoroscopy (live x-ray) for guidance.4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.5) No more than two nerve root levels should be injected using transforaminal blocks.6) No more than one interlaminar level should be injected at one session.7) In the therapeutic phase, 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support a series of three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The documentation submitted for review indicates that the injured worker underwent bilateral transforaminal lumbar ESI at L4/L5 and L5/S1 3/2015, which resulted in 95% improvement in pain for five months. However, per the ODG guidelines with regard to anesthetic sedation: There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of particular concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. The documentation submitted for review does not indicate that the injured worker suffers from anxiety. Absent such evidence, the request is not medically necessary.