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| Case Number: | CM15-0024814 | | |
| Date Assigned: | 02/17/2015 | Date of Injury: | 12/06/2010 |
| Decision Date: | 07/14/2015 | UR Denial Date: | 01/22/2015 |
| Priority: | Standard | Application Received: | 02/09/2015 |

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, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 44 year old male, who sustained an industrial injury on 12/6/10. He has reported initial complaints of a back injury. The diagnoses have included lumbago, lumbar degenerative disc disease (DDD), facet pain, thoracic pain and thoracic/lumbosacral neuritis/radiculitis. Treatment to date has included acupuncture, chiropractic, injections, activity modifications, rest and diagnostics. Currently, as per the physician progress note dated 10/7/14, the injured worker complains of aching and burning pain across the low and mid back with burning, numbness and tingling in the anterior and posterior thighs. He states that the pain level stays at about a 7/10 on pain scale on a regular basis. He complains of insomnia and sleepiness. The physical exam reveals tenderness in the mid thoracic spine and the paraspinal muscles of the mid thoracic spine and lumbar spine. The range of motion is slightly decreased in all fields. He has decreased sensation of the anterior thighs. The current medications included naproxen and Tylenol as needed. The physician noted that he reviewed the Magnetic Resonance Imaging (MRI) of the thoracic spine dated 6/3/14 and it shows mild disc desiccation at multiple levels. The MRI of the lumbar spine dated 4/14/14 reveals posterior disc bulge and moderate facet joint arthritis. The physician also notes that the electromyography (EMG) of the bilateral lower extremities is consistent with bilateral S1 radiculitis. However, there are no diagnostic reports noted in the records. There is also no previous acupuncture or chiropractic sessions noted in the records. The current medications included Naproxen and Tylenol as needed. The physician requested treatment included Transforaminal lumbar epidural steroid injection bilateral s1 under fluoroscopy guidance conscious sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal lumbar epidural steroid injection bilateral s1 under fluoroscopy guidance conscious sedation: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Epidural steroid injection.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, transforaminal lumbar epidural steroid injection bilateral S1 under fluoroscopy with conscious sedation is not necessary. Epidural steroid injections are recommended as an option for treatment of radicular pain. The criteria are enumerated in the Official Disability Guidelines. The criteria include, but are not limited to, radiculopathy must be documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing; initially unresponsive to conservative treatment (exercises, physical methods, non-steroidal anti-inflammatories and muscle relaxants); 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 6 to 8 weeks, etc. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response, etc. See the guidelines for details. There is no evidence-based literature to make a firm recommendation as to sedation during the ESI. The use of sedation introduces potential diagnostic and safety issues making it unnecessary 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. Routine use is not recommended except for patients with anxiety. The general agent recommended is a benzodiazepine. While sedation is not recommended for facet injections (especially with opiates) because it may alter the anesthetic diagnostic response, sedation is not generally necessary for an epidural steroid injection is not contraindicated. As far as monitored anesthesia administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of postoperative care. In this case, the injured worker's working diagnoses are low back pain; lumbar degenerative disc disease; lumbar discogenic pain; fast with a L5 - S1; bilateral S1 radiculitis; and thoracic pain. The most recent progress note of the medical records dated October 7, 2014. Each worker has low back pain and mid back pain. The injured worker had a prior lumbar epidural steroid injection January 2014. There was 6 to 8 weeks of pain relief than 50%. The treating provider is requesting conscious sedation for the epidural steroid injection procedure. Routine use of sedation is not recommended except for patients with anxiety. As far as monitored anesthesia administered by someone besides the surgeon, there should be evidence of a pre-anesthetic exam and evaluation, prescription of anesthesia care, completion of the record, administration of medication and provision of

postoperative care. There is no documentation of anxiety medical record. There is no documentation of a pre- anesthetic exam or a prescription for anesthesia care. There is no clinical rationale for conscious sedation. Consequently, absent clinical documentation of anxiety, guideline non- recommendations recommending the routine use of sedation, transforaminal lumbar epidural steroid injection bilateral S1 under fluoroscopy with conscious sedation is not medically necessary.