MAXIMUS Federal Services

Case Number:	CM15-0033425		
Date Assigned:	02/26/2015	Date of Injury:	05/28/2010
Decision Date:	04/13/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	02/23/2015

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

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 44-year-old male sustained an industrial injury on 5/28/10, with subsequent ongoing low back pain. In a PR-2 dated 2/2/15, the injured worker complained of lumbar spine pain 9/10 on the visual analog scale. The injured worker had run out of Norco and wanted to maintain himself off Norco, using other techniques such as acupuncture and epidural steroid injections. The injured worker reported receiving over 60% pain relief for over six weeks from previous epidural steroid injection one year prior. Physical exam was remarkable for lumbar spine with limited range of motion with pain radiating to the left leg and ankle and 4/5 strength to the left lower extremity. The treatment plan included left L4 and L5 transforaminal epidural injection (TFE) injection under fluoroscopy and a lumbar corset to help with instability of the lumbar spine. The physician noted that the injured worker was now off narcotics. On 2/18/15, Utilization Review noncertified a request for left L4 and L5 transforaminal epidural injection (TFE) injection under fluoroscopy and lumbar corset noting lack of documentation of objective improvement from previous injections and citing ACOEM and CA MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4 and L5 transforaminal epidural injection (TFE) injection under fluoroscopy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs), therapeutic.

Decision rationale: Per progress report dated 02/02/15, the patient presents with low back pain. The request is for LEFT L4 AND L5 TRANSFORAMINAL EPIDURAL INJECTION (TFE) INJECTION UNDER FLUOROSCOPY. Patient's diagnosis per the RFA dated 02/11/15 is Lumbar Radiculopathy. As of 02/02/15, the patient does not appear to be on any medications. It should also be noted that as of 12/29/14, the patient completed 8 sessions of aquatic therapy, reporting "only minimal relief of pain that lasts for a few hours." Patient is considered permanent and stationary. The MTUS Guidelines has the following regarding ESI under chronic pain section page 46 and 47, "Recommended as an option for treatment of radicular pain." MTUS has the following criteria regarding ESI's, under its chronic pain section: Page 46, 47 "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. No more than two nerve root levels should be injected using transforaminal blocks. Criteria for the use of Epidural steroid injections: 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)." ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs), therapeutic: With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008) Not recommended post-op. The evidence for ESI for postlumbar surgery syndrome is poor. (Manchikanti, 2012)" Per progress report dated 02/02/15, the treater states, "The patient has had lumbar epidurals in the past, which have been over 60% helpful for over six weeks. It has been a long time since he had one of these injections, but he is now ready to undergo this again to help with his pain control." Per QME report dated 09/10/14, "An MRI of the lumbar spine date 12/14/10 showed a broad-based disc bulge with superimposed disc extrusion in the LEFT lateral recess likely compressing on the descending LEFT SI nerve root at L5-S1. Posterior facet hypertrophy and bilateral moderate neural foraminal stenosis was also noted on L5-S1. At L4-L5 there was a broad based disc bulge with superimposed central disc protrusion which effaced the lateral recesses LEFT greater than right. There were degenerative changes of the remainder of the lumbar spine and prior posterior laminectomy." In the same report during the Physical examination to the lumbar spine on 09/10/14, revealed positive straight leg raise test bilaterally, left greater than the right. It would appear that the treater provided sufficient documentation to satisfy MTUS requirements. Treater has documented radiculopathy supported by physical examination and corroborated with imaging study. Treater has documented improvement from prior injection. However, the patient is status

post bilateral L4-5 and L5-S1 interlaminar decompression, foraminotomies, and right L5-S1 discectomy, 12/19/11. ODG does not recommend postoperative lumbar ESI. The request does not meet guideline indications. Therefore, the request IS NOT medically necessary.

Lumbar support/corset: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Per progress report dated 02/02/15, the patient presents with low back pain. The request is for LUMBAR SUPPORT/CORSET. Patient's diagnoses per the RFA dated 02/11/15 is Lumbar Radiculopathy. The patient is status post bilateral L4-5 and L5-S1 interlaminar decompression, foraminotomies, and right L5-S1 discectomy (12/19/11). As of 02/02/15, the patient does not appear to be on any medications. It should also be noted that as of 12/29/14, the patient completed 8 sessions of aquatic therapy, reporting "only minimal relief of pain that lasts for a few hours." Patient is considered permanent and stationary. ODG guidelines state braces are not recommended for prevention and for treatment. It is an option for fracture, spondylosis, documented instability, and for nonspecific low back pain (very low quality evidence). Additionally, ACOEM Guidelines page 301 states, "Lumbar support has not been shown to have any lasting benefit beyond the acute phase of symptom relief." Page 9 of ACOEM Guidelines also states, "The use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security." Treater has not provided reason for the request. In this case, the patient suffers from low back pain that is not related to compression fractures, spondylolisthesis, or instability. The use of lumbar supports such as back braces has not been proven for the management of post-operative pain, and ODG does not support the use of back braces merely for preventive purposes. Therefore, this request IS NOT medically necessary.