

Case Number:	CM14-0177825		
Date Assigned:	10/31/2014	Date of Injury:	11/06/2013
Decision Date:	12/15/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/27/2014

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, has a subspecialty in Interventional Spine 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 patient is a 61 year old female with an injury date of 11/06/13. Based on the 07/15/14 progress report provided by [REDACTED] the patient complains of chronic low back pain rated 8-9/10 that radiates down the bilateral lower extremities and right shoulder pain. Physical examination to the lumbar spine revealed tenderness to palpation to the lumbar paraspinals, and mild right sacroiliac tenderness. Range of motion was decreased, especially on extension 0 degrees. Straight Leg Raise, Patrick's and Gaellen's tests were positive. The patient was given an epidural steroid injection for the low back, date unspecified, and did not have any significant relief. Her current medications include Nortriptyline, Effexor, Naproxen, Hydrochlorothiazide, Amlodipine and Simvastatin. Patient is experiencing depression which appears to be due to her pain, and provider feels "the patient would be better served by being treated by clinical psychologist." Diagnostic Studies 07/15/14:- X-ray of the hip and pelvis 11/07/13: shows some degenerative changes to the right and left hips- CT scan of the Lumbar Spine 07/11/13: shows multilevel degenerative changes- MRI of the Lumbar Spine 12/20/13: shows evidence of multilevel spondylosis with disc bulges primarily at L3-4 and L4-5.- X-ray of the right shoulder 11/14/13: shows glenohumeral and acromioclavicular joint arthritis- MR Arthrogram of the right shoulder 07/10/14: shows full thickness tear of the supraspinatus, acromioclavicular joint arthropathy, tear of superior glenoid labrum, increased rotator interval and increased signal of the long head of the biceps. The utilization review determination under reconsideration is dated 10/01/14. The rationale follows: 1) Right Sided L5-S1 Transforaminal Epidural Steroid Injection: "outcomes from previous ESI do not meet guideline criteria." 2) Refer To Psychologist for Depression: "the request fails to specify the concerns to be addressed." [REDACTED]. [REDACTED] is the requesting provider and he provided treatment reports from 02/06/14 - 07/15/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right-Side L5-S1 Transforaminal Epidural Steroid Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Chapter 7, Page 127

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI's Page(s): 46-47.

Decision rationale: The patient presents with chronic low back pain rated 8-9/10 that radiates down the bilateral lower extremities and right shoulder pain. The request is for Right Side L5-S1 Transforaminal Epidural Steroid Injection. Physical examination to the lumbar spine on 07/15/14 revealed tenderness to palpation to the lumbar paraspinals, and mild right sacroiliac tenderness. Range of motion was decreased, especially on extension 0 degrees. Straight Leg Raise, Patrick's and Gaellen's tests were positive. MRI of the Lumbar Spine 12/20/13: shows evidence of multilevel spondylosis with disc bulges primarily at L3-4 and L4-5. 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," and "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." Provider has described radicular pain and physical examination on 07/15/14 revealed positive straight leg raise test. MRI findings regarding the L5-S1 level is not documented, and there is no diagnosis of radiculopathy. ESI's are not recommended unless the patient's radicular symptoms are corroborated by imaging studies. Furthermore, per progress report dated 07/15/14, the patient was given an epidural steroid injection for the low back, date unspecified, and did not have any significant relief. MTUS requires documentation of functional improvement for repeat blocks. The request does not meet guideline criteria. Therefore, this request is not medically necessary.

Refer to Psychologist for Depression: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment Page(s): 101-102. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127 Psychologist

Decision rationale: The patient presents with chronic low back pain rated 8-9/10 that radiates down the bilateral lower extremities and right shoulder pain. The request is for Refer to

Psychologist for Depression. Per progress report dated 07/15/14, the patient's current medications include Nortriptyline, Effexor, Naproxen, Hydrochlorothiazide, Amlodipine and Simvastatin. MTUS page 101 Psychological treatment states, "Recommended for appropriately identified patients during treatment for chronic pain." Psychological treatments for depression is also recommended and ODG guidelines support up to 13-20 sessions and up to 50 sessions in case of severe depression if progress is being made. ACOEM Practice Guidelines, 2nd Edition (2004), page 127 has the following: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." UR letter dated 10/01/14 states "the request fails to specify the concerns to be addressed." Per progress report dated 07/15/14, provider states that "the patient is experiencing depression which appears to be due to her pain," and he feels "the patient would be better served by being treated by clinical psychologist." Provider has addressed the request, which is indicated by guidelines. Therefore, this request is medically necessary.