

<b>Case Number:</b>	CM14-0218766		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	10/18/2011
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	12/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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 female who sustained an industrial related injury on 10/18/11. The injured worker had complaints of neck pain and low back pain. Physical examination findings included a negative Spurling's test and a negative Finkelstein's test. The diagnosis was lumbar muscle strain. Treatment included physical therapy, epidural steroid injections for both cervical and lumbosacral areas, and two more epidural steroid injections for the low back on 7/3/13 and 5/1/14. Medications included Baclofen and Zolof. The treating physician requested authorization for a lumbosacral epidural steroid injection and referral to a comprehensive pain management and functional restoration program. On 12/17/14 the requests were non-certified. Regarding the epidural steroid injection, the utilization review (UR) physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted there was no detailed evidence of recent conservative treatment with physical therapy, home exercise program, chiropractic, or acupuncture that had been tried and failed. Therefore, the request was non-certified. Regarding a comprehensive pain management and functional restoration program, the UR physician cited the MTUS guidelines and noted there was no evidence of psychological evaluation/ results therefore the request was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Lumbosacral Epidural Steroid Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** The MTUS Guidelines recommend the use of epidural steroid injections for short-term treatment of radicular pain. The goal is to decrease pain and improve joint motion, resulting in improved progress in an active treatment program. The radiculopathy should be documented by examination and by imaging studies and/or electrodiagnostic testing. Additional requirements include documentation of failed conservative treatment, functional improvement with at least a 50% reduction in pain after treatment with an initial injection, and a reduction in pain medication use lasting at least six to eight weeks after prior injections. The submitted and reviewed records indicated the worker was experiencing neck and lower back pain. These records reported the worker had improved symptoms when prior medication was injected near the spinal nerves, but there was no detailed description of the specific benefit or how long the benefit lasted. No documented examination findings from near the time of the request were submitted for review. There were no imaging or electrodiagnostic findings submitted for review. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for lumbosacral epidural steroid injections at an unspecified side or level is not medically necessary.

## **Referral to a Comprehensive Pain Management and Functional Restoration Program: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPs) Page(s): 49.

**Decision rationale:** A functional restoration program (FRP) is a type of interdisciplinary pain program specifically tailored for those with chronic disabling occupational musculoskeletal disorders. The focus is to maximize function rather than eliminate pain. While additional quality research is needed, the MTUS Guidelines recommend this treatment. A two week trial is recommended with additional treatment after demonstrating both patient-reported and objective improvement. The submitted and reviewed records indicated the worker was experiencing neck and lower back pain. The documented pain assessments were minimal and did not include many of the elements recommended by the Guidelines. There was no discussion describing special issues that sufficiently supported this request. In the absence of such evidence, the current request for a referral to a comprehensive pain management and functional restoration program is not medically necessary.

