

<b>Case Number:</b>	CM15-0103447		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	06/25/2012
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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, 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 60 year old female who sustained an industrial injury on 06/25/2012. Current diagnoses include cervicgia, lumbago, lumbar radiculopathy, lumbar disc protrusion, sacroiliac joint dysfunction, depression, myalgias, right ankle pain sprain/strain, knee pain, and insomnia. Previous treatments included medications and injections. Report dated 03/31/2015 noted that the injured worker presented with complaints that included neck pain with radiation to the bilateral trapezius, low back pain with radiation to the right lower extremity with numbness and tingling, and right ankle pain. Pain level was 6 out of 10 on a visual analog scale (VAS). Physical examination was positive for straight leg raise on right, positive facet loading test, and tenderness to palpation over the cervical paraspinal muscles and upper trapezius muscle. The treatment plan included requests for Tramadol, tizanidine, Elavil, omeprazole, continue with Naproxen, request for urinalysis, request for a lumbar epidural steroid injection, request for cognitive behavioral therapy evaluation and treatment for chronic pain management and depression, and follow up in 4 weeks. Disputed treatments include cognitive behavioral therapy evaluation and treatment 1 x 6, and lumbar epidural steroid injection at the right L4-L5 and L5-S1 with fluoroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Psych referral for cognitive behavioral therapy evaluation and treatment 1 times 6:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R Page(s): 100-102 of 127.

**Decision rationale:** Regarding the request for psychological evaluation/treatment, Chronic Pain Medical Treatment Guidelines state that psychological evaluations are recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected using pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury, or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. Guidelines go on to state that an initial trial of 3 to 4 psychotherapy visits over 2 weeks may be indicated. Within the documentation available for review, the provider mentions depression, but there are no noted symptoms or findings consistent with this condition to support the need for specialty evaluation and treatment. In the absence of clarity regarding those issues, the currently requested psychological evaluation/treatment is not medically necessary.

**Lumbar epidural steroid injection right L4-L5 and L5-S1 under fluoroscopy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46 of 127.

**Decision rationale:** Regarding the request for epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Within the documentation available for review, there are no current clinical findings supporting a diagnosis of radiculopathy corroborated by imaging and/or electrodiagnostic studies. In the absence of such documentation, the currently requested epidural steroid injection is not medically necessary.