

<b>Case Number:</b>	CM15-0184469		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	04/15/2013
<b>Decision Date:</b>	11/02/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 36 year old female, who sustained an industrial injury on 04-15-2013. She has reported subsequent low back and bilateral shoulder pain and was diagnosed with lumbar herniated nucleus pulposus, left sciatica, bilateral shoulder rotator cuff tears and myospasm. MRI of the lumbar spine dated 10-08-2014 showed L4-L5 dehiscence of the nucleus pulposus indicative of disc degeneration, large downward extrusion of the nucleus pulposus, moderate decrease in the AP sagittal diameter of the lumbosacral canal, thickening of the ligamentum flavum, mild bony hypertrophy of the articular facets and thickening of the posterior arches, L5-S1 6.5 mm downward extrusion of the nucleus pulposus indenting the anterior portion of the lumbosacral sac causing mild decrease in AP sagittal diameter of the lumbosacral canal and tear of the annulus of the posterior nucleus pulposus. Work status was documented as off work. Treatment to date for pain has included medication, application of heat and cold, acupuncture, shockwave therapy, massage, traction, exercise, chiropractic treatment, physical therapy, and transcutaneous electrical nerve stimulator (TENS) unit which were noted to have failed to significantly relieve the pain. Percutaneous epidural decompression neuroplasty of the lumbosacral nerve roots with lumbar facet blocks was performed on 05-08-2015. In a progress note dated 08-07-2015, the injured worker reported right shoulder pain that was rated as 6 out of 10 and back and left shoulder pain that was rated 8 out of 10 with numbness left greater than right. Objective examination findings showed tenderness of the lumbar spine, decreased flexion, extension and left lateral flexion, bilateral shoulder tenderness left greater than right and decreased range of motion bilaterally. The physician noted in the treatment plan that a

psychological pain consultation was being requested due to reports of anxiety, irritability and coping difficulty with ongoing pain and functional limitations. There were no subjective or objective findings documented in the examination to further clarify the nature of the psychological issues and there were no psychiatric diagnoses listed in the record. An MRI of the lumbar spine was also noted as being requested but there was no explanation as to the reason for ordering the imaging study. A request for authorization of psych-bio behavioral pain management 6-12 sessions over 5-6 weeks and MRI of the lumbar spine was submitted. As per the 08-21-2015 utilization review, the requests for psych-bio behavioral pain management 6-12 sessions over 5-6 weeks and MRI of the lumbar spine were non-certified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Psych-Bio Behavioral Pain Management 6-12 Sessions over 5-6 weeks: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment.

**Decision rationale:** The California chronic pain medical treatment guidelines section on psychological treatment states: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short- term effect on pain interference and long-term effect on return to work. The following stepped- care approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005) Psychological treatment in particular cognitive behavioral therapy has been found to be particularly effective in the treatment of chronic pain. As this patient has continued ongoing pain, this service is indicated per the California MTUS and thus is medically necessary.

## **MRI Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore the request is not medically necessary.