

Case Number:	CM15-0206976		
Date Assigned:	10/23/2015	Date of Injury:	09/01/2010
Decision Date:	12/04/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	10/20/2015

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 59 year old female who sustained an industrial injury September 1, 2010. Past treatment included physical therapy for approximately two months with no prolonged relief. According to a treating physician's progress report dated March 31, 2015, the injured worker is status post spinal cord stimulator permanent implant, February 9, 2015. She reports good coverage. She also reported to having increased stress and feeling depressed and went to an emergency room three times for anxiety and chest pain; work up negative. Medication at this visit included Norco, Zanaflex, Naproxen, Topamax (hasn't taken for 6 month) Pheniramine, Buspar, and Wellbutrin. A treating physician's progress report dated August 28, 2015, found the injured worker presenting with complaints of poor sleep secondary to anxiety and taking Norco for lumbar pain. She reports having fallen and breaking a front tooth. Current medication as noted in the March 31, 2015 visit. Objective findings; looks tired and affect flat (same as March 2015); lumbar- sensation decreased left posterolateral thigh (L4); straight leg raise positive left at 60 degrees and negative right. The physician documented an MRI L3-4, L4-5, L5-S1 with annular tear (not dated). Diagnoses are lumbar radiculopathy L4-5, L5-S1 with failed physical therapy; cervical radiculopathy; depression and anxiety. Treatment plan included weaning of medication, check blood work, and at issue, a request for authorization for left L4-S1 epidural steroid injection and a psych evaluation-testing chronic pain. According to utilization review dated September 17, 2015, the request for a psych evaluation and treatment was modified to a psych evaluation. The request for Left L4-S1 epidural steroid injection under fluoroscopic guidance is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-S1 epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 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) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The patient has the documentation of back pain however there is no included imaging or nerve conduction studies in the clinical documentation provided for review that collaborates dermatomal radiculopathy found on exam for the requested level of ESI. Therefore, criteria have not been met and the request is not medically necessary.

Psych evaluation / testing chronic pain: Overturned

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

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.