

<b>Case Number:</b>	CM15-0020822		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	07/09/2003
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 reported an injury on 07/09/2003. The mechanism of injury was unspecified. Her diagnoses include cervical discopathy, shoulder pain, status post L4-5 and L5-S1 lumbar interbody fusion, right knee arthritis and chronic effusion, right knee degenerative joint disease, left knee degenerative joint disease, status post left total knee arthroplasty, headaches, head contusion, obesity, left shoulder lipoma, status post left knee replacement. Her past treatments include surgery, physical therapy, and medications. On 12/15/2014, the injured worker complained of ongoing neck, low back, and bilateral knee pain. The injured worker rated her low back pain at an 8/10, right hip at a 7/10, neck at 8/10, shoulders at 7/10, and wrists at a 5/10 to 6/10. The physical examination of the lumbar spine revealed significant tenderness in the paralumbar musculature, and tenderness in the paraspinous musculature bilaterally. The lumbar range of motion was also indicated to be decreased. Her relevant medications were noted to include oxycodone, gabapentin, tramadol, alprazolam, and Senokot. The treatment plan included pain management consultation for lumbar spine and epidural injections. A rationale was not provided. A Request for Authorization form was submitted on 12/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain Management Consultation for Lumbar Spine Epidural Injections: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office visits.

**Decision rationale:** The request for pain management consultation for lumbar spine epidural injections is not medically necessary. According to the Official Disability Guidelines, office visits are determined upon evaluation management of patients play a critical role in the proper diagnosis and return to function of an injured worker. They are also individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The injured worker was indicated to have chronic low back pain. However, there was a lack of documentation of a clear rationale for pain management consultation prior to a lumbar epidural steroid injection. There was a lack of documentation in regard to signs and symptoms of clinical stability upon examination to support the request. As such, the request is not supported by the evidence based guidelines. Therefore, the request is not medically necessary.