

<b>Case Number:</b>	CM14-0212508		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	04/16/2013
<b>Decision Date:</b>	02/23/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

### 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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabn, 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 53-year-old female who reported an injury on 04/16/2013. The injury reportedly occurred when the patient was hit by a forklift. She was diagnosed with lower back pain. Her past treatments were noted to include medications, physical therapy, and surgery. On 11/17/2014, the injured worker reported right sided lower back pain with radiation to the lower extremity, buttocks, thigh, and calves. She indicated her pain was 7/10 to 8/10 in severity. She indicated she has had physical therapy with minimal relief. Upon physical examination, she was noted to have moderate discomfort in the mid lumbar spine on the right and straight leg raise test was negative bilaterally. Her medications were not provided. The treatment plan was noted to include to obtain x-rays and MRI of the cervical spine to rule out stenosis, facet and epidural injections to improve the right L3-4 radiculopathy and back pain, and a followup visit. A request for authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L3-L4 facet injection qty: 1.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2014 Low Back, Facet joint diagnostic blocks (injections).

**Decision rationale:** The request for right L3-4 facet injection qty. 1.0 is not medically necessary. According to the California MTUS/ACOEM Guidelines, invasive techniques such as facet injections are of questionable merit; however, pain physicians believe the diagnostic and/or therapeutic injections may have benefits. More specifically, the Official Disability Guidelines state that therapeutic facet joint blocks can be used with other evidence based conservative care such as home exercise and/or physical therapy to facilitate functional improvement. The guidelines also suggest indicators of pain related to facet joint pathology which are tenderness to palpation in paravertebral areas, normal sensory examination, absence of radicular findings and normal straight leg raise exam. Additionally, the guidelines also suggest the use of therapeutic intra-articular injections for no more than 1 block is recommended and there should be no evidence of radicular pain, spinal stenosis or previous fusion, no more than 2 levels at 1 time and there should be evidence in the formal plan of additional evidence based on activities and exercises. The clinical documentation provided does indicate that the patient has moderate discomfort in the mid lumbar spine on the right and straight leg raise testing was negative bilaterally. However, there is no evidence of a formal plan of additional evidence based activities and exercise. Additionally, an independent MRI evaluation was not provided. Given the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.

**Right L3-L4 epidural injection qty: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 113, Chronic Pain Treatment Guidelines Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The California MTUS Guidelines recommend epidural steroid injections for the treatment for radicular pain. Additionally, the guidelines recommend that radiculopathy must be documented by physical examination corroborated by imaging studies. The patient should be initially unresponsive to conservative treatment. It is recommended that injections be performed using fluoroscopy for guidance. The clinical documentation provided no evidence of radiculopathy noted within the clinical documentation and the treating physician did not provide an MRI of the lumbar spine and/or electrodiagnostic studies. Additionally, there is a lack of neurological deficits such as a positive straight leg raise, decreased motor strength and sensation. Furthermore, there was no documentation of failed conservative care. Moreover, the request as submitted does not include the use of fluoroscopy for guidance. Given the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.

**Pain management referral qty 1.00: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) 7, page(s) 124.

**Decision rationale:** The request for pain management referral qty. 1.00 is not medically necessary. The California MTUS/ACOEM Guidelines state consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability and permanent residual loss and/or patient's fitness for return to work. The clinical documentation does indicate the treating physician plans to provide the injured worker with injections; however, there is no rationale provided for the pain management, referrals to pain management should fulfill clear goals and treatment. Additionally, there were no goals outlined for the pain management referral for the patient. Given the above information, the request is not supported by the guidelines. As such, the request for pain management referral qty. 1.00 is not medically necessary.