

<b>Case Number:</b>	CM15-0121685		
<b>Date Assigned:</b>	07/02/2015	<b>Date of Injury:</b>	10/20/2013
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	05/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2015

### 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

### 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 51 year old female who sustained an industrial injury on October 20, 2013. She has reported injury to the low back and right knee and has been diagnosed with sprain of knee and leg, disc disorder lumbar, lumbar radiculopathy, and low back pain. Treatment has included medication, medical imaging, acupuncture, chiropractic care, and physical therapy. Range of motion of the lumbar spine was restricted due to pain. On palpation, paravertebral muscles, spasm, tenderness, tight muscle band and trigger point was noted on the right side. Lumbar facet loading was positive on the right side. Straight leg raise was positive on the right side in a supine position at 50 degrees. The treatment request included a transforaminal epidural steroid injection right L5-S1 and pain management counseling.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal epidural steroid injection right L5-S1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injections, page 46.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); However, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any specific neurological deficits with intact motor strength and reflexes or remarkable diagnostics to support the epidural injections. There is no report of acute new injury, flare-up, progressive neurological deficit, or red-flag conditions to support for pain procedure. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Lumbar epidural injections may be an option for delaying surgical intervention; however, there is not surgery planned or identified pathological lesion noted. Criteria for the epidurals have not been met or established. The Transforaminal epidural steroid injection right L5-S1 is not medically necessary and appropriate.

**Pain Management Counseling 1 time a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions, page 23; Psychological Treatment, Pages 101-102.

**Decision rationale:** Current request was modified to authorize for 4 sessions. Submitted reports have not described what psychological pain counseling and evaluation are needed or identified what specific goals are to be obtained from the additional psychological evaluation beyond the pain psychological evaluation with CBT certified to meet guidelines criteria. MTUS guidelines support continued treatment with functional improvement; however, this has not been demonstrated here whereby independent coping skills are developed to better manage episodic chronic issues, resulting in decrease dependency and healthcare utilization. Current reports have no new findings or clinical documentation to support the continued Psychotherapy counseling. Additionally, if specific flare-up has been demonstrated, the guidelines allow for initial trial of 3-4 sessions with up to 6-10 visits over 5-6 weeks; however, there is no specific symptom complaints or clinical findings to support for the continued pain counseling treatment demonstrated. The Pain Management Counseling 1 time a week for 6 weeks is not medically necessary and appropriate.