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| <b>Case Number:</b>   | CM13-0001508 |                              |            |
| <b>Date Assigned:</b> | 03/03/2014   | <b>Date of Injury:</b>       | 06/09/2010 |
| <b>Decision Date:</b> | 05/20/2014   | <b>UR Denial Date:</b>       | 07/01/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/15/2013 |

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Management, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 59 year-old male with a date of injury of 06/09/2010. The listed diagnoses per [REDACTED] dated 06/19/2013 are: 1) Lumbago 2) Displacement of lumbar intervertebral disc without myelopathy 3) Myalgia 4) Neuroforaminal stenosis at L1-2 through L5-A1 According to report dated 06/19/2013 by [REDACTED], the patient presents with constant pain in his lower back that radiates into his left leg to the plantar portion of his foot. He describes pain as aching, pulsing, throbbing and burning. He rates his pain as 8/10. He also complains of difficulty falling asleep due to pain. The patient states pain is reduced with rest. He is not taking any medications

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **MEDICAL CLEARANCE FROM INTERNAL MEDICINE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) and Occupational Medical Practice Guidelines (OMPG), 2nd Edition, 2004, Chapter 7, Independent Medical Examinations, page 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46-47.

**Decision rationale:** This patient presents with constant pain in his lower back that radiates into his left leg and to the plantar portion of his foot. The treating physician is requesting a medical clearance from an internal medicine specialist prior to proceeding with the epidural steroid injection. ACOEM Practice Guidelines, 2nd Edition (2004), page 127 states "health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification." In this case, the treating physician is requesting a referral to an internal medicine specialist for clearance prior to an Epidural Steroid Injection. ESI is not extremely complex and does not require an internal medicine clearance. MTUS guidelines pg 46, 47 does not require a medical clearance for an epidural injection. Recommendation is for denial.

**PYSCHOLOGICAL EVALUATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100-101.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46-47.

**Decision rationale:** This patient presents with constant pain in his lower back that radiates into his left leg and to the plantar portion of his foot. The treating physician is requesting a psychological evaluation "to determine if the patient is sufficiently stable and secure emotionally" prior to an epidural injection. While ACOEM Practice Guidelines, 2nd Edition (2004), page 127 states "health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise," ESI is not complex, does not require psychological clearance. MTUS guidelines pages 46-47 do not require a psychological evaluation prior to an epidural injection. Recommendation is for denial

**COLD UNIT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Cold Unit, 9th Edition (web).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG). Continuous-Flow Cryotherapy.

**Decision rationale:** This patient presents with constant pain in his lower back that radiates into his left leg and to the plantar portion of his foot. The treating physician is requesting a cold/hot therapy unit for treatment of sequelae arising out of patient's injuries. The MTUS and ACOEM guidelines do not discuss Cold Therapy units specifically, therefore ODG guidelines are referenced. ODG guidelines have the following regarding continuous-flow cryotherapy:

"Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated." In this case, ODG guidelines do not support this type of device other than for post-operative recovery, which does not apply to this patient. The request is not medically necessary and appropriate.

**HOME LUMBAR TRACTION UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** This patient presents with constant pain in his lower back that radiates into his left leg and to the plantar portion of his foot. The treating physician is requesting a home lumbar traction unit. ACOEM page 300 states the following regarding lumbar traction: "Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended." Traction units are not supported by ACOEM guidelines for treatment of low back pain. The lumbar traction unit is not medically necessary and appropriate.

**LUMBAR LSO BRACE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** This patient presents with constant pain in his lower back that radiates into his left leg and to the plantar portion of his foot. The treating physician requests lumbar brace for prophylactic purposes to avoid exacerbation of the current injury. The ACOEM Guidelines page 301 on lumbar bracing states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines regarding lumbar supports states, "not recommended for prevention, however, recommended as an option for compression fractures and specific treatment of spondyloisthesis, documented instability, and for treatment of nonspecific lower back pain (very low quality evidence but may be a conservative option)." In this case, the patient does not present with fracture, instability or spondylolisthesis to warrant lumbar bracing. ODG guidelines do discuss non-specific back pain as an indication but states that there is very low quality evidence for this. The Lumbar LSO Brace is not medically necessary and appropriate