MAXIMUS Federal Services

Case Number:	CM13-0006449		
Date Assigned:	08/27/2013	Date of Injury:	10/29/2012
Decision Date:	01/13/2014	UR Denial Date:	07/19/2013
Priority:	Standard	Application Received:	08/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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 55 Y, F with a date of injury 10/29/12, with diagnoses of low back pain with radicular symptoms bilateral lower extremities worse on right, MRI 12/28/12 reveals degenerative disc disease at the level of L3-L4, L4-L5, L5-S1, lumbar spine spondylosis at the level of L4-L5 and L5-S1, cervical spine sprain/strain, cervical spine degenerative disc disease with radicular symptoms to bilateral upper extremities worse on the right side at the level of C4-C5 and C5-C6 based on MRI 12/20/12, mild cervical canal stenosis at the level of C4-C5, paracervical and bilateral upper trapezius muscle spasm. The progress report dated 6/20/13 by [redacted] noted that diagnostic medial branch blocks of the bilateral L4-L5 and L5-S1 level were requested to identify the source of low back pain. Based on the patient's physical signs and symptoms, which indicated more severe pain local to lumbosacral area than radicular symptoms to lower extremities and positive physical examination of pain with axial loading and facet loading along with lumbar spine MRI study, which reveals spondylosis of the L4-L5 and L5-S1 bilaterally. It was noted that the patient had not responded to conservative treatments of physical therapy and medications for last few months. The ThermoCool hot and cold contrast therapy with compression was requested for a period of 60 days for pain control, reduction of inflammation and increased circulation. No other rational was provided by the treater regarding what area the continuous-flow cryotherapy was for.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic Bilateral L4-L5 and L5-S1 Medial Branch Blocks under Fluoroscopic Guidance: Overturned

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 Official Disability Guidelines (ODG), Lumbar Facet Joint Diagnostic Blocks.

Decision rationale: The progress report dated 6/20/13 by [redacted] noted that diagnostic medial branch blocks of the bilateral L4-L5 and L5-S1 level were requested to identify the source of low back pain. Based on the patient's physical signs and symptoms, which indicated more severe pain local to lumbosacral area than radicular symptoms to lower extremities and positive physical examination of pain with axial loading and facet loading along with lumbar spine MRI study, which reveals spondylosis of the L4-L5 and L5-S1 bilaterally. It was noted that the patient had not responded to conservative treatments of physical therapy and medications for last few months. The bilateral L4-L5 and L5-S1diagnostic blocks appear to be reasonable in this case and are supported by ODG guidelines. MTUS is silent on this. Authorization is recommended

Rental of a ThermoCool Hot and Cold Contrast Therapy Unit with Compression for 60 days: 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 Official Disability Guidelines (ODG), Shoulder and Knee Chapters, Continuous Flow Cryotherapy.

Decision rationale: According to the progress report dated 6/20/13 by [redacted] the ThermoCool hot and cold contrast therapy with compression was requested for a period of 60 days for pain control, reduction of inflammation and increased circulation. No other rational was provided by the treater regarding what area the continuous-flow cryotherapy was for. MTUS is silent on this. ODG guidelines support the use of continuous-flow cryotherapy up to 7 days for post-operative shoulder as well as knee. The requested use in this case is not supported by ODG. Recommendation is for denial.