

<b>Case Number:</b>	CM13-0031531		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	10/29/2012
<b>Decision Date:</b>	02/19/2014	<b>UR Denial Date:</b>	09/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2013

### 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 Texas and Oklahoma. 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 year old female who reported injury on 10/29/2012. The mechanism of injury was noted to be a slip and fall where the patient did the splits. The patient was noted to have low back pain with occasional radicular symptoms into the lower extremities. The patient was noted to have muscle spasms in the lumbar spine along with tenderness in the lumbar paraspinal region bilaterally. There was noted to be tenderness in the midline lumbar spine. The diagnoses were noted to be low back pain with radicular symptoms bilateral lower extremities worse on right side, lumbar spine spondylosis, and right knee pain status post endoscopic operation. The request was made for bilateral L4-5 and L5-S1 medial branch blocks as a diagnostic test, Hyalgan injections, Norco, tizanidine, and ThermoCool hot and cold contrast therapy with compression.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L4-L5 and L5-S1 Medial Branch Block (MBB):** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Medial Branch Block.

**Decision rationale:** ACOEM Guidelines indicate that facet joint injections are not recommended for the treatment of low back disorders. However, despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic. As such, there is the application of the Official Disability Guidelines, which indicate that facet joint medial branch blocks as therapeutic injections are not recommended except as a diagnostic tool as minimal evidence for treatment exists. The Official Disability Guidelines recommend that for the use of diagnostic blocks, the patient have facet-mediated pain which includes tenderness to palpation in the paravertebral area over the facet region, a normal sensory examination, absence of radicular findings and a normal straight leg raise exam. The patient's motor examination was noted to include decreased motor strength at 4/5 on the left in the iliopsoas, quadriceps, tibialis anterior, extensor hallucis longus and gastrocnemius. The patient's sensation was noted to be intact. The patient was noted to have tenderness over the lumbar spinous process, interspinous ligaments and posterior superior iliac space along the facet joint. The patient was noted to have a straight leg raise that produced back pain in the sitting position and lumbar extension caused pain over the facet joints. The Faber test was noted to be positive. The patient's flexion was noted to be decreased. The clinical documentation submitted for review indicated the patient had tenderness to palpation in the paravertebral area, a normal sensory examination, absence of radicular findings, and a normal straight leg raise examination. The request for a bilateral L4-5 and L5-S1 medial branch block is medically necessary.

**ThermoCool hot and cold contrast therapy with compression:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter; Chronic Pain Medical Treatment Guidelines pg 91.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Continuous-flow cryotherapy.

**Decision rationale:** ACOEM Guidelines recommend at home applications of heat and cold packs before or after exercises and are as effective as those performed by a therapist. Per the authorization request, the request per the physician was noted to be for 60 days for pain control, reduction of inflammation, and increased circulation. It was further documented that a multimodality treatment was preferred over simple ice and heat packs for the additional benefit of compression as well as increase patient compliancy and the regulation of temperature to prevent over icing or over heating which could cause tissue damage and delays in functional restoration. As such, secondary guidelines were sought. Per Official Disability Guidelines, continuous flow cryotherapy is recommended as an option after surgery but not for non-surgical treatment. The clinical documentation submitted for review failed to indicate the patient had recent surgery to support the usage of cryotherapy; however, additionally Official Disability Guidelines is in agreement with California Medical Treatment Guidelines which recommend at home local applications of cold packs in the first few days of acute complaint, thereafter

applications of heat packs or cold packs. Given the above, the request for a ThermoCool hot and cold contrast therapy with compression is not medically necessary.