

<b>Case Number:</b>	CM13-0035697		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	12/25/2003
<b>Decision Date:</b>	02/14/2014	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2013

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 57-year-old female who reported an injury on 12/25/2003. The patient is currently diagnosed with lumbar spine disc bulging, probable right knee internal derangement, and status post total hip replacement in 2004. The patient was seen by [REDACTED] on 09/10/2013. Physical examination revealed diminished sensation in the left mid and lateral calf. Treatment recommendations included a lumbar epidural steroid injection, combination stimulator unit, supplies, and contrast compression pads.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One lumbar epidural injection:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehabilitation efforts. Radiculopathy must be documented by physical examination and

corroborated by imaging studies and/or electrodiagnostic testing. As per the clinical notes submitted, the physical examination on the requesting date of 09/10/2013 only revealed diminished sensation in the left lower extremity. There is no documentation of radiculopathy upon physical examination. There were also no imaging studies provided for review to corroborate a diagnosis of radiculopathy. There is no indication of a failure to respond to recent conservative treatment, including exercises, physical methods, nonsteroidal anti-inflammatory drugs (NSAIDs), and muscle relaxants. Based on the clinical information received, the lumbar epidural injection is not medically necessary.

**Hot/cold contrast unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation the Official Disability Guidelines (ODG) Low back Chapter, Cold/Heat Packs.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state that physical modalities have no proven efficacy in treating acute low back symptoms. At home local applications of heat or cold are as effective as those performed by therapists. As per the clinical notes submitted, the patient's physical examination on the requesting date of 09/10/2013 only revealed diminished sensation in the left lower extremity. The medical necessity for the requested unit has not been established. Therefore, the hot/cold contrast unit is not medically necessary.

**Contrast compression pads:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back Chapter, Cold/Heat Packs.

**Decision rationale:** As the request for the hot and cold contrast unit has not been authorized, the current request for contrast compression pads is also not medically necessary.

**Combo stimulator unit with supplies:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** The California MTUS Guidelines state that transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence based functional restoration. As per the clinical notes submitted, the patient's physical examination on the requesting date of 09/10/2013 only revealed diminished sensation in the left lower extremity. There is no documentation of a significant musculoskeletal or neurological deficit. Therefore, the combo stimulator unit with supplies is not medically necessary.