

<b>Case Number:</b>	CM13-0053492		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	05/01/2012
<b>Decision Date:</b>	03/10/2014	<b>UR Denial Date:</b>	11/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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:

This 24 year-old patient sustained an injury on 5/1/12 while employed by [REDACTED]. Requests under consideration include Lumbar ESI L4-L5, L5-S1 and Thermo-cool Hot-Cool. Report of 8/8/13 from [REDACTED] noted patient with chronic neck pain with neurogenic symptoms of her right upper extremity diagnosed with CRPS; lower back complaints of pain which radiates to her left buttock, but "she denies any tingling or numbness or radicular symptoms down to her leg." Exam showed 4/5 motor strength throughout right upper extremity; 2+DTRs; negative Spurling; diffuse sensory issue at C4-C8 and T1 with limited range; lumbar spine with 5/5 throughout lower extremities; muscle spasm; DTRs 2+; TTP; SLR negative with limited range. Diagnoses included sympathetically maintained pain of RUE; right shoulder rotator cuff tear; dysfunctional RUE; left shoulder tendinitis; cervical strain; and lumbar spine x-rays normal. Plan was to have periodic blocks for her RSD; arthroscopic shoulder repair. Report of 10/7/13 from [REDACTED] noted s/p diagnostic arthroscopy of right shoulder with SAD, acromioplasty for debridement and partial thickness repair. Treatment plan was for PT, CPM machine, and TTD. Requests above were non-certified on 11/4/13 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar ESI L4-5, L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** This 24 year-old patient sustained an injury on 5/1/12 while employed by [REDACTED]. Requests under consideration include Lumbar ESI L4-L5, L5-S1 and ThermoCool Hot-Cold. Report of 8/8/13 from [REDACTED] noted patient with chronic neck pain with neurogenic symptoms of her right upper extremity diagnosed with CRPS; lower back complaints of pain which radiates to her left buttock, but "she denies any tingling or numbness or radicular symptoms down to her leg." Exam showed 4/5 motor strength throughout right upper extremity; 2+DTRs; negative Spurling; diffuse sensory issue at C4-C8 and T1 with limited range; lumbar spine with 5/5 throughout lower extremities; muscle spasm; DTRs 2+; TTP; SLR negative with limited range. Diagnoses included sympathetically maintained pain of RUE; right shoulder rotator cuff tear; dysfunctional RUE; left shoulder tendinitis; cervical strain; and lumbar spine x-rays normal. Plan was to have periodic blocks for her RSD; arthroscopic shoulder repair. Report of 10/7/13 from [REDACTED] noted s/p diagnostic arthroscopy of right shoulder with SAD, acromioplasty for debridement and partial thickness repair. Treatment plan was for PT, CPM machine, and TTD. Submitted reports show no neurologic deficits of the lumbar spine and lower extremities. 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. Criteria for the LESI have not been met or established. The Lumbar ESI L4-L5, L5-S1 is not medically necessary and appropriate.

**ThermoCool Hot-Cold:** 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), online edition, Section: Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 10/9/2013).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder-Continuous-flow cryotherapy, pages 909-910.

**Decision rationale:** This 24 year-old patient sustained an injury on 5/1/12 while employed by [REDACTED]. Requests under consideration include Lumbar ESI L4-L5, L5-S1 and Thermo-cool Hot-Cold. Report of 8/8/13 from [REDACTED] noted patient with chronic neck pain with neurogenic symptoms of her right upper extremity diagnosed with CRPS; lower back complaints of pain which radiates to her left buttock, but "she denies any tingling or numbness or radicular symptoms down to her leg." Exam showed 4/5 motor strength throughout right upper extremity; 2+DTRs; negative Spurling; diffuse sensory issue at C4-C8 and T1 with limited range; lumbar spine with 5/5 throughout lower extremities; muscle spasm; DTRs 2+; TTP; SLR negative with limited range. Diagnoses included sympathetically maintained pain of RUE; right

shoulder rotator cuff tear; dysfunctional RUE; left shoulder tendinitis; cervical strain; and lumbar spine x-rays normal. Plan was to have periodic blocks for her RSD; arthroscopic shoulder repair. Report of 10/7/13 from [REDACTED] noted s/p diagnostic arthroscopy of right shoulder with SAD, acromioplasty for debridement and partial thickness repair. Treatment plan was for PT, CPM machine, and TTD. MTUS Guidelines is silent on specific use of cold compression therapy with pad and wrap, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post shoulder surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. Submitted reports have not demonstrated medical necessity outside guidelines criteria. The ThermoCool Hot-Cold is not medically necessary and appropriate.