

Case Number:	CM14-0016731		
Date Assigned:	02/21/2014	Date of Injury:	02/01/2010
Decision Date:	07/23/2014	UR Denial Date:	01/20/2014
Priority:	Standard	Application Received:	02/10/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 54-year-old male with a 2/1/09 date of injury. He sustained cumulative injury to his shoulders, neck and back from repetitive use. On 12/19/13, the patient had 5-7/10 pain in his neck, wrists, lower back, and right knee. Objective exam: tenderness to palpation over the cervical and lumbar spine, and decreased ROM. A Lumbar MRI on 2/18/13 shows multilevel disc disease, facet hypertrophy at L3-4 and L4-5 and L5-S1 disc herniations. At L4-5 and L5-S1, there is a disc protrusion that abuts the thecal sac associated with spinal canal narrowing as well as bilateral neuroforaminal narrowing. Diagnostic Impression is Cervicalgia, Lumbago, and Myalgia. Treatment to date: medication management, activity modification. A UR decision dated 1/20/14 denied the request for a lumbar ESI since there is an isolated sensory deficit without significant reflex or myotome deficit and without corroborative MRI findings or electrodiagnostic findings confirming the appropriate level of radiculopathy. Lumbar facet injections were denied because the patient is having radicular symptoms. A cold unit was not certified because there is no evidence-based therapeutic efficacy and conventional ice packs are equally effective. A lumbar exercise kit is not certified because there is no documentation of precise indications for this injured worker with chronic neuromusculoskeletal pain. A cervical exercise kit was not certified since there is no documentation of indications for an exercise kit with chronic neuromusculoskeletal pain syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL SPINAL INJECTION AT L4-L5 AND L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AMA Guides (Radiculopathy).

Decision rationale: CA MTUS does not support epidural injections in the absence of objective radiculopathy. In addition, CA MTUS criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. Furthermore, repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. However, there is no clear description of objective radiculopathy on examination. On the most recent progress note on 12/18/13, there is no neurological examination documented. The guidelines only support lumbar ESIs in the setting of objective radiculopathy. Therefore, the request for Lumbar Epidural Spinal Injection at L4-5 and L5-S1 was not medically necessary.

LUMBAR FACET JOINT BLOCK AT MEDIAL BRANCH L3-L4,L4-L5 AND L5-S1:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter: Facet Injections.

Decision rationale: CA MTUS supports facet injections for non-radicular facet mediated pain. In addition, ODG criteria for facet injections include documentation of low-back pain that is non-radicular, failure of conservative treatment (including home exercise, PT, and NSAIDs) prior to the procedure for at least 4-6 weeks, no more than 2 joint levels to be injected in one session, and evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint therapy. However, this patient is noted to have subjective radicular symptoms. There is no evidence of facet-mediated disease at L3-4, L4-5, and L5-S1. In addition, guidelines only support facet blocks at 2 joint levels, and this request is for 3 joint levels. Therefore, the request is for Lumbar Facet Joint Block at Medial Branch L3-4, L4-5 and L5-S1 was not medically necessary.

COLD UNIT: 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) Knee Chapter: Cryotherapy.

Decision rationale: CA MTUS does not address this issue specifically. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, this patient is not documented to be post-operative. Guidelines do not support cryotherapy in the non-operative setting. There is no clear discussion that the patient has failed treatment with conventional ice packs. Therefore, the request for the Cold Unit was not medically necessary.

LUMBAR EXERCISE KIT: 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) Knee Chapter: Exercise Equipment.

Decision rationale: CA MTUS does not address this issue. Before the requested exercise kit can be considered medically appropriate, it is reasonable to require documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. ODG states that exercise equipment is considered not primarily medical in nature, and that DME can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in a patient's home. There is no clear documentation provided as to the components and rationale as to why this patient needs both a cervical and lumbar exercise kit. Therefore, the request for the Lumbar Exercise Kit was not medically necessary.

CERVICAL EXERCISE KIT: 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) ODG Knee Chapter: Exercise Kit.

Decision rationale: Before the requested exercise kit can be considered medically appropriate, it is reasonable to require documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. ODG states that exercise equipment is considered not primarily medical in nature, and that DME can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in

a patient's home. However, there is no clear rationale provided as to why this patient needs a home exercise kit for the cervical spine, as well as the lumbar spine. He has a 2009 date of injury, and it is unclear what type of exercise program he has already failed. Therefore, the request for a Cervical Exercise Kit was not medically necessary.

HOME LUMBAR TRACTION UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter: Traction.

Decision rationale: CA MTUS states that 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. However, there is no rationale provided as to why this patient needs lumbar traction despite the recommendations by the evidence-based guidelines that lumbar traction is not effective. There is no documentation of prior trials of lumbar traction and efficacy. It is unclear what type of traction unit is being requested. Guidelines do not support powered traction. Therefore, the request for a Home Lumbar Traction Unit was not medically necessary.