

<b>Case Number:</b>	CM14-0038855		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	06/17/2013
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	03/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2014

### 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 Medicine, 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 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:

The injured worker is a 42 year old female who reported an injury to her low back. The clinical note dated 02/27/14 indicates the injured worker complaining of low back pain. Upon exam, tenderness was identified in the two lower lumbar segments. The injured worker was able to demonstrate 10 degrees of extension in the lumbar region as well as 20 degrees of bilateral lateral bending and 40 degrees of bilateral rotation. The injured worker was identified as having a positive straight leg raise on the right with a positive Lesegue's sign on the right as well. Slight weakness was identified at the gastrocnemius and the anterior tibia on the right. There is an indication the injured worker stated the initial injury occurred with a fall in 06/2013. The clinical note dated 10/31/13 indicates the injured worker having a positive straight leg raise on the left at 60 degrees. Decreased sensation was identified in the dorsum of the left foot. Left sided dorsa flexion weakness was also identified. The clinical note dated 09/24/13 indicates the injured worker able to demonstrate 4+/5 strength on the right with the EHL, the anterior tibialis, and the gastrocnemius. The procedural note dated 10/22/13 indicates the injured worker having undergone an L4-5 selective nerve root block on the right. The clinical note dated 11/19/13 indicates the injured worker continuing with 9-10/10 pain in the low back. The note does indicate the injured worker having a 40% reduction in pain with the continued use of medications. The utilization review dated 03/19/14 resulted in a denial for an epidural steroid injection in the lumbar region as well as a cold therapy unit and an electro-stim unit as no imaging studies or clinical information had been submitted confirming the need for an epidural steroid injection. Insufficient information had been submitted regarding the injured worker's need for post-surgical continuous flow cryotherapy. And finally, the use of interferential stimulation is not generally recommended. However, if pain is ineffectively controlled due to the diminished effectiveness of medications, interferential units are indicated.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar Transforaminal Epidural Steroid Injections Right L4 and L5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation AMA Guides (Radiculopathy; Official Disability Guidelines Low Back and Pain Chapter.

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

**Decision rationale:** The documentation indicates the injured worker complaining of ongoing low back pain. There was also an indication the injured worker has previously undergone a selective nerve root block at the L4-5 level. However, no objective data was submitted regarding the injured worker's reduction in pain following the injection. Therefore, it is unclear if the injured worker would benefit from a follow up epidural steroid injection. The request for an epidural steroid injection on the right at L4-5 is not medically necessary.

### **Motorized Cold Therapy Unit for Purchase (Low Back):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, 308.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs.

**Decision rationale:** The documentation indicates the injured worker complaining of low back pain with radiating pain into the lower extremities. The use of cold therapy is indicated in the lumbar region provided the injured worker meets specific criteria to include the use of local at home products is indicated in order to reduce the injured worker's swelling and to increase the injured worker's functional capabilities. Previous studies have determined local at-home products are as effective as commercial products. Given that local at home products are just as effective as commercially available products; the request for a motorized cold therapy unit is not fully indicated. The request for a motorized cold therapy unit for purchase for low back pain is not medically necessary.

### **Stim Electrotherapy x 60 days Rental (Low Back):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Transcutaneous electrotherapy Page(s): 116-7.

**Decision rationale:** The request for an electrotherapy stimulation unit for a 60 day rental is not medically necessary. The use of an electrostimulation unit is indicated for injured workers who have significant functional deficits likely to benefit from the use of an e-stim device. However, the use of e-stim is not indicated as a primary treatment modality until an injured worker has undergone a one month home based trial with an objective functional improvement. No information was submitted regarding the injured worker's previous trial of an e-stim device. Additionally, recent studies have shown evidence that the effectiveness of the proposed treatment is lacking. Given these factors, the request is not indicated as medically necessary.