

<b>Case Number:</b>	CM15-0169367		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	12/31/2010
<b>Decision Date:</b>	10/14/2015	<b>UR Denial Date:</b>	08/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 52 year old female who sustained an industrial injury on 12-21-10. She had complaints of lower back pain. Treatments include: medication, physical therapy and chiropractic care. Progress report dated 7-6-15 reports continued complaints of lower back pain that radiates down the left leg into the foot. The pain increases with sitting, walking or standing over 15-20 minutes, forward bending, squatting, stooping, climbing or descending stairs, twisting, turning and forceful pushing and pulling. The pain is rated 8 out of 10. Physical examination of the lumbar spine revealed antalgic gait, tenderness on palpation, 5/5 strength, limited range of motion, muscle spasm and positive SLR. Diagnoses include: left lumbar radiculopathy in the direction of L3-5 and S1 dermatomes, status post lumbar spine fusion on 10-17-13 with continuous pain and radicular symptoms. Plan of care includes: request lumbar epidural steroid injection transforaminal on left L3-4, L4-5, and L5-S1, recommend post injection motorized cold therapy unit for purchase only, request continue medications; Norco, soma and compound analgesic cream. Work status: defer to primary treating physician. Follow up in 4 weeks. The patient has had history of right knee surgery. The medication list includes Norco and Soma. The patient has had MRI of the lumbar spine with abnormal results of disc protrusion and tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal lumbar epidural steroid injection, left L3-L4, L4-L5 and L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** Request: Transforaminal lumbar epidural steroid injection, left L3-L4, L4-L5 and L5-S1. The MTUS Chronic Pain Guidelines regarding Epidural Steroid Injections state, "The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." Per the cited guideline criteria for ESI are "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)." Consistent objective evidence of lower extremity radiculopathy was not specified in the records provided. Lack of response to conservative treatment including exercises, physical methods, NSAIDs and muscle relaxants was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Conservative therapy notes were not specified in the records provided. A response to recent rehab efforts including physical therapy or continued home exercise program were not specified in the records provided. As stated above, epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The records provided did not specify a plan to continue active treatment programs following the lumbar ESI. As stated above, ESI alone offers no significant long-term functional benefit. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. With this, it is deemed that the medical necessity of request for Transforaminal lumbar epidural steroid injection, left L3-L4, L4-L5 and L5-S1 is not fully established for this patient.

**Motorized cold therapy unit for purchase:** 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), Low Back, Cold/heat packs.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 09/22/15) Cold/heat packs.

**Decision rationale:** Motorized cold therapy unit for purchase. MTUS guidelines American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 12 Low Back Complaints Page 299. Physical Therapeutic Interventions Knee & Leg (updated 07/10/15) Continuous-flow cryotherapy. Per the ACOEM guidelines cited below "At-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold." Per the cited guidelines Continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment". The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. "There is limited information to support active vs. passive cryo units. Cryotherapy after TKA yields no apparent lasting benefits, and the current evidence does not support the routine use of cryotherapy after TKA." Per the cited guidelines cold packs is "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004)" The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. Therefore, there is minimal evidence supporting the use of cold therapy for this diagnosis. In addition, any evidence of acute pain was not specified in the records provided. Rationale for not using a simple cold pack at home was not specified in the records provided. Patient has received an unspecified number of the PT visits for this injury till date. The records provided do not specify a detailed response to conservative measures including PT for this injury. The previous PT visit notes are not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications is not specified in the records provided. The medical necessity of the request for Motorized cold therapy unit for purchase is not fully established in this patient.