

Case Number:	CM15-0214009		
Date Assigned:	11/03/2015	Date of Injury:	12/29/2014
Decision Date:	12/22/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	10/30/2015

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 was a 34 year old female, who sustained an industrial injury, December 29, 2014. The injured worker was undergoing treatment for thoracic spine sprain and L4-L5 discogenic pain with right lower extremity radiculopathy. According to progress note of October 1, 2015, the injured worker's chief complaint was low back pain, middle back pain and right leg pain. The objective findings were decreased range of motion of the lumbosacral spine. There was midline and paraspinal tenderness of the lumbar spine. The straight leg raises were positive in the seated and supine positions on the right and negative on the left. The injured worker previously received the following treatments continue home lumbosacral stabilization exercises, lumbar spine MRI on 7/17/15 showed evidence of disc desiccation with annular tear and protrusion at L4-L5 and thoracic spine MRI was negative on 7/24/15. The RFA (request for authorization) dated August 10, 2015, the following treatments were requested an L4-L5 transforaminal epidural injection. The UR (utilization review board) denied certification on October 13, 2015; for an L4-L5 transforaminal epidural injection. The patient had received an unspecified number of PT visits for this injury. Per the note dated 10/19/15 the patient had complaints of low back pain with radiation in right foot. Physical examination of the lumbar spine revealed mild antalgic gait, muscle spasm, tenderness on palpation, limited range of motion, positive SLR and normal sensory and motor examination. The medication list includes Diclofen and Soma.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Transforaminal Epidural Steroid Injection: Upheld

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

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

Decision rationale: L4-5 Transforaminal Epidural Steroid Injection. 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 electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)." The patient has received an unspecified number of PT visits for this injury. The detailed 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 L4-5 Transforaminal Epidural Steroid Injection is not fully established for this patient. The request is not medically necessary.

Motorized Cold Therapy Unit For Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 12/02/15), Cold/heat packs.

Decision rationale: Motorized Cold Therapy Unit For Purchase 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. There is minimal evidence supporting the use of cold therapy."Therefore there is minimal evidence supporting the use of cold therapy for this diagnosis. In addition 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. 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. The request is not medically necessary.