

<b>Case Number:</b>	CM15-0221902		
<b>Date Assigned:</b>	11/17/2015	<b>Date of Injury:</b>	06/29/2012
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 41 year old male, who sustained an industrial injury on 6-29-12. The injured worker was diagnosed as having lumbar intervertebral disc without myelopathy; thoracic or lumbosacral neuritis or radiculitis unspecified; lumbar discogenic pain. Treatment to date has included physical therapy; home exercise program-stretching; medications. Diagnostics studies included MRI lumbar spine (3-2-14). Currently, the PR-2 notes dated 9-18-15 indicated the injured worker presents to this office for pain management follow-up. He reports his low back pain has returned following a lumbar epidural steroid injection (March 2015). However, he reports a significant pain relief for approximately four to five months following that last injection. Objective findings are documented by the provider noting "Lumbar spine shows decreased range of motion with spasm and tenderness to palpation. There is positive sciatic notch tenderness bilaterally with positive straight leg raise bilaterally. Sensation is intact throughout; motor is 5 out of 5 throughout; deep tendon reflexes are 2+ and equal." The treatment plan includes a repeat lumbar epidural steroid injection transforaminal approach noting "he did have greater than 50% pain reduction for approximately 4 to 5 months. He is also requesting a Motorized Cold therapy unit for purchase to be used post injection." A Request for Authorization is dated 10-26-15. A Utilization Review letter is dated 10-16-15 and non-certification for Lumbar Epidural Steroid Injection using transforaminal approach and Motorized Cold therapy unit for purchase. A request for authorization has been received for Lumbar Epidural Steroid Injection using transforaminal approach and Motorized Cold therapy unit for purchase.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar Epidural Steroid Injection using transforaminal approach: 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:** Epidural steroid injections are recommended by the MTUS Guidelines when the patient's condition meets certain criteria. The criteria for use of epidural steroid injections include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, 2) Initially unresponsive to conservative treatment, 3) Injections should be performed using fluoroscopy for guidance, 4) If used for diagnostic purposes, a maximum of two injections should be performed, and a second block is not recommended if there is inadequate response to the first block, 5) No more than two nerve root levels should be injected using transforaminal blocks, 6) No more than one interlaminar level should be injected at one session, 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, 8) No more than 2 ESI injections. In this case, on the most recent examination, there was no objective evidence of radiculopathy in the injured worker. The request for lumbar epidural steroid injection using transforaminal approach 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, Knee Chapter, Cryotherapies.

**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 Chapter/Cold/Heat Packs Section.

**Decision rationale:** MTUS guidelines support the use of at-home local applications of cold in first few days of acute complaint, thereafter, applications of heat or cold. The ODG supports the use of cold packs 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. 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. However, there is no indication that a commercially bought heat/ice unit has any advantage over an at-home application of ice or heat. In this case, a motorized unit is requested to be used post-epidural steroid injection. The associated request for epidural steroid injection is not supported. The request for motorized cold therapy unit for purchase is not medically necessary.