

<b>Case Number:</b>	CM15-0045519		
<b>Date Assigned:</b>	03/17/2015	<b>Date of Injury:</b>	03/15/2013
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2015

### 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, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 50 year old female who sustained an industrial injury on March 15, 2013. She has reported right knee pain, right shoulder pain, and low back pain and has been diagnosed with lumbosacral sprain/strain, right sacroiliac joint arthropathy, right shoulder pain, and right knee pain secondary to osteoarthritis. Treatment has included medication, injections, and physical therapy. Currently the injured worker complains of tenderness to palpation on the medial and lateral side of the right knee, medial border of the patella and had pain with range of motion and crepitation on the right knee. The treatment request included a motorized cold therapy unit, purchase and S1 joint steroid injection, right.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motorized cold therapy unit, purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hip and Pelvis Chapter, SI Joint Blocks.

**Decision rationale:** The patient has ongoing right knee pain, right shoulder pain and low back pain. The current request is for SI steroid injection, right. The attending physician states the patient continues to have severe low back pain, worse on the right side. She has received therapies and medications with no improvement of her pain. MRI of the lumbar spine showed no lumbar spine pathology, and based on physical examination and location of pain the patient will likely benefit from an SI joint injection. ODG guidelines state SI joint injections are recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy. ODG further states that, "The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed below: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH)." In this case, the attending physician notes one positive exam test from the list above. He also notes a positive SLR which is not indicative of SI pain. The available documentation does not establish medical necessity per ODG guidelines, and as such recommendation is for denial. The request is not medically necessary.

**SI joint steroid injection, right:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESIs.

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

**Decision rationale:** The patient has ongoing right knee pain, right shoulder pain and low back pain. The current request is for Motorized Cold Therapy Unit. The attending physician states that he would like to order a motorized cold therapy unit for purchase, to be utilized post injection. The MTUS and ACOEM Guidelines are silent with regards to this request. However, ODG Guidelines under the Low Back chapter on Cold/Heat Packs recommends at-home, local applications of cold pack in the first few days of acute complaints; thereafter, applications of heat packs. ODG further states that mechanical circulating units with pumps have not been proven to be more effective than passive hot/cold therapy. In this case, the ODG guidelines do not recommend mechanical circulating units over passive hot/cold therapy. Furthermore, the request states that the unit is to be purchased following SI injection. Since the SI injection is not recommended, the motorized cold therapy unit would not be recommended. As such, recommendation is for denial. The request is not medically necessary.