

Case Number:	CM15-0123206		
Date Assigned:	07/07/2015	Date of Injury:	05/22/2012
Decision Date:	07/31/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	06/25/2015

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: 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 70 year old male who sustained an industrial /work injury on 5/22/12. He reported an initial complaint of low back pain that radiated to the lower extremities along with knee pain. The injured worker was diagnosed as having bilateral knee medial meniscus tear with patellofemoral joint chondromalacia and L3-4, L4-5 stenosis with spondylolisthesis neurogenic claudication. Treatment to date includes medication, physical therapy, and injections. Currently, the injured worker complained of low back pain radiating to his bilateral lower extremities involving bilateral posterior thigh and calf, worse on the right side and bilateral knee pain. Per the primary physician's report (PR-2) on 6/16/15, examination noted tenderness to touch over the midline of lumbar spine, tenderness on bilateral lumbosacral area, diminished deep tendon reflexes bilaterally in patellar tendon and Achilles tendon, positive slump test, bilaterally. Lumbar extension causes pain over the facet joints to the left and right, diminished range of motion of the lumbar spine: flexion at 50 degrees, extension at 30 degrees, right tilt at 30 degrees, left tilt at 30 degrees, right rotation at 30 degrees and left rotation at 30 degrees. The requested treatments include lumbar epidural steroid injection and motorized cold therapy unit, purchase, lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injections, page 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); However, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any specific neurological deficits or remarkable diagnostics to support the epidural injections. There is no report of acute new injury, flare-up, progressive neurological deficit, or red-flag conditions to support for pain procedure. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Lumbar epidural injections may be an option for delaying surgical intervention; however, there is not surgery planned or identified pathological lesion noted. Criteria for the epidurals have not been met or established. The Lumbar epidural steroid injection Qty: 1.00 is not medically necessary and appropriate.

Motorized cold therapy unit, purchase, lumbar spine: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, pages 381-382.

Decision rationale: MTUS/ACOEM guidelines do not specifically address this; however, the Official Disability Guidelines state Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment such as lumbar injections and postoperative use generally may be up to 7 days, including home use without necessity for home unit purchase. Submitted reports have not demonstrated the medical necessity outside the recommendations of Guidelines criteria. As the Lumbar epidural steroid injection is not medically necessary and appropriate; thereby the Motorized cold therapy unit, purchase, lumbar spine is not medically necessary and appropriate.